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Let's chat: Willingness to communicate and the development of a destigmatizing campaign

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Let's Chat:
Willingness to Communicate and the Development
Of a Destigmatizing Campaign

Ethan D. Smith

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JAMES MADISON UNIVERSITY
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Abstract

Low treatment rates for depression are commonly observed among young adults of typical college age in particular. Fear of social judgement makes stigma a commonly identified barrier to depression treatment. What is unclear is how the willingness of university students to communicate about depression may influence or be influenced by stigma. Guided by the Theory of Planned Behavior and the Health Belief Model, the present thesis investigates the stigma attitudes of students toward depression, as well as their willingness to communicate about depression. To do this, an online survey was conducted with depression stigma scales and adapted willingness to communicate (WTC) scales. Results indicate that students are more willing to talk with friends about depression than they are with family about depression or with mental healthcare providers, and that students perceive greater stigma in others than they report having themselves. Also, with the exception of perceived stigma, each of the WTC and stigma scales and subscales were correlated with and predicted each other, suggesting a reciprocal relationship of influence between WTC and stigma. Focus groups were conducted which supplemented and added to the quantitative findings with themes of WTC with an intimate few, perceived stigma, help-provision desires, and perceived public ignorance of severity. These themes contributed to the development of campaign materials intended to encourage more frequent and destigmatizing conversations about depression among college students. Campaign message-related themes of preference for explicit expressions of relevancy and privacy concerns contributed to message revision. The study concludes with recommendations for further research and advocacy work.

CHAPTER 1: INTRODUCTION

An estimated 26% of U.S. adults have a diagnosable mental disorder (Kessler, et al., 2005), which is roughly 82.6 million people (U.S. Census Bureau, 2014). A health issue which concerns a fourth of the nation's population demands obvious attention. The need for research is made all the more paramount when considering that only 13% of Americans receive treatment for mental health issues (NIMH, 2008), meaning very few individuals with mental health disorders receive the treatment which could improve their quality of life. Approximately 41.3 million people go untreated every year (Kessler, et al., 2005; NIMH, 2008), including students. Young adults within the age range of traditional college students are perhaps the most important demographic to study when discussing mental health because of their position on the timeline of cognitive development. Many, if not most, mental disorders begin onset by early adulthood (Kessler, et al., 2005). The existence of mental disorders is greatest among individuals aged 16-24 years (Gulliver, Griffiths, & Christensen, 2010), placing traditional college-aged students in the midst of college when they may first experience a mental disorder. Therefore, understanding the mental health of college students is often the ideal area of inquiry for studying mental health (Zivin, et al., 2009).

The number of students in college with mental health issues is steadily increasing (Kitzrow, 2003; Mowbray, et al., 2006). As a result, there has been an increase in some treatment seeking behaviors (Mowbray et al., 2006). However, overall, the number of students seeking mental health mirrors that of the population at large; that is to say, mental health help seeking remains strikingly low. Fewer than half of students with mood

disorders, only 24% of students diagnosed with depression, and less than 20% of those with anxiety disorders seek treatment (Hunt & Eisenberg, 2010). Hints of cultures of silence on college and university campuses come from Collins and Mowbray (2005), who found that only 16% of schools have specifically outlined policies of outreach and recruitment for their campus counseling centers. Furthermore, an incredibly low percentage of faculty (14.7%) and students (4.5%) can say they are “very familiar” with their university counseling centers (Becker, et al., 2002). These statistics are particularly alarming considering undergraduate students have poorer mental health than graduate students and are less likely to seek mental health services (Wyatt & Oswalt, 2012).

At the turn of the 21st century, Americans had begun to broaden their definitions of what constitutes mental illness (Phelan, et al., 2000), with most Americans now reporting personally knowing someone who has received treatment for mental health issues (Pescosolido et al., 2000), increased awareness of environmental and relational influences on mental health, and increased willingness to seek informal help (Swindle et al., 2000). Americans are also significantly more likely to turn to prescription medication and mental health professionals for help (Swindle et al., 2000) and overwhelmingly believe treatment will positively affect mental health issues (Pescosolido et al., 2000). It is curious, then, as to why modern treatment rates remain so low if society has seen such a dramatic shift in education and awareness.

Further trends suggest the disparity may be related to attitudinal antecedents, as the number of individuals who describe mental illness in terms consistent with dangerous or violent behavior has nearly doubled (Phelan et al., 2000). The vast majority of Americans believe those with serious mental illness pose a risk to both themselves and to

others (Link, et al., 1999; Pescosolido, et al., 1999), and their preference to maintain significant social distance between themselves and those with mental health problems is still incredibly high (Martin, et al., 2000). “For example, on average, nearly half of all respondents (48.4%) report an unwillingness to interact with the person described in the schizophrenia vignette, and nearly 40 percent (37.4%) indicate a similar unwillingness to interact with persons suffering from major depression” (Pescosolido et al., 2000, p. 30). While most Americans indicate at least a willingness to be friendly with those with mental health difficulties, 75% of participants are unwilling to have someone whom they consider to have a serious mental illness marry a family member and 67.4% are unwilling to have such individuals as co-workers (Link et al., 1999; Martin et al., 2000).

Depression

One of the most prevalent mental health disorders is depression. Approximately one in ten adults reported experiencing a depressive disorder and 4% meet the criteria for major depression (CDC, 2012). Major depression involves feelings which interfere with an individual’s ability to live out and enjoy the various aspects of life (NIMH, 2014). Depressive disorders are cognitive illnesses caused by genetic, biological, environmental, and psychological determinant factors (NIMH, 2014). Rates of depression treatment mirror general mental health trends; only half of Americans who experience an episode of major depression receive treatment, often contributing to suicide, the tenth leading cause of death in America (NAMI, 2014). And the likely link between treatment disparity and stigma seems apparent once more in recalling the finding from Pescosolido et al. (2000), who found that nearly 40% of individuals indicate an unwillingness to interact with persons suffering from major depression.

Among the current targeted demographic, recent studies have found 30% of college students report experiencing life-disrupting depression (ACHA, 2012), which is related to academic performance (Eisenberg, 2007) and the likelihood of increased smoking, drinking, other substance abuse, and unsafe sex (Cranford et al., 2009; Weitzman, 2004; Griswold et al., 2008; Glantz et al., 2009). Perhaps most paramount, more than 6% of college students seriously consider suicide and 1% report attempting to take their own life (ACHA, 2012). Unlike adults for whom suicide is the tenth leading cause of death, suicide is the third leading cause of death for individuals between the ages of 15 and 24 (NCHS, 2012). The dangers of depression and suicide highlight Hunt and Eisenberg's (2010) finding that only 24% of students diagnosed with depression seek treatment. Even ignoring the undiagnosed students with depression, a 24% treatment rate among those suffering is alarmingly low for such a serious mental health condition.

Stigma and Communication

Despite significantly increased knowledge about mental health, Americans are still dramatically uncomfortable with mental health issues. More recent research suggests that attitudes towards actually seeking help for mental illness have become increasingly negative over the past 40 years (Mackenzie et al., 2014). Researchers (Pescosolido et al., 2000; Collins & Mowbray, 2005; Becker et al., 2002; Mowbray et al., 2006; Hunt & Eisenberg, 2010) suggest that such a disparity can be attributed to the production and proliferation of particular stigmas concerning mental health, some coining the term "enduring stigmatization" (Pescosolido et al., 2000, p. 32). This has led to the U.S. Surgeon General's Report on Mental Health identifying stigma as an obstacle in the way of proper treatment for mental health issues (Office of the Surgeon General, 1999).

In psychological sciences, the term stigma is largely considered to refer to a negatively constructed schema; that is to say, a stigma is a framework for seeing and constructing the outside world which directs an individual towards having a negative opinion of a certain idea, event, or individual. Famed sociologist Erving Goffman, in his pioneering research on stigma, describes the term as a process in which a group of individuals are categorically disqualified from social acceptance through a communicatively socialized simplification of their personal qualities or physical attributes which identifies or marks the group as nonconforming to cultural norms (Goffman, 1963; Smith, 2011). Individuals can be seen to fall into three categories concerning stigmatization: those stigmatized, those who wisely accept and empathize with the stigmatized, and those who perpetuate stigmas (Goffman, 1963). Further empirical evidence from Smith (2012) has been shown to differentiate the empathetic “wise” between active supporters who communicate opposition to stigma and passive supports who do not.

Communication is the primary experience through which stigma is constructed and proliferated and, in attempting to explain stigma communication, Smith (2007) developed a conceptual model of stigma messages. These messages include four types of content cues: (1) marking individuals for categorization into a particular, stigmatized group, (2) labeling a stigmatized group as separate from the rest of society, (3) placing responsibility for membership within a stigmatized group as a choice of the members, resulting from innate immorality of character, and (4) describing the dangers the group poses to the rest of society and reminders for unmarked members to protect themselves and support the group (Smith, 2007a). Other scholars (Ashforth & Kreiner, 1999) have

detailed the kinds of stigma (physical, social, and moral) involved in communicated messages. Link and Phelan (2001) developed a critical model of stigma which also accounts for the lived experiences of the stigmatized and the exercise of social, economic, and/or political power on the part of those who discredit the marked and stigmatized. A recognition of dimensions of power rejects a falsely dichotomous view of stigma and suggests that, through resistance, stigmatized groups might move across a continuum of stigmatization (Link & Phelan, 2001).

Mental health stigma is considered an obstacle following indications that it can create in students a fear of disclosure and increased social distance (Becker et al., 2002; Collins & Mowbray, 2005). A recent systematic review of quantitative and qualitative studies on mental health-related stigma and help-seeking revealed that while stigma is not always the highest ranked barrier to treatment, it is still a hugely impactful deterrent for students, particularly when related to disclosure concerns (Clement et al., 2014).

Health Communication and Mental Health

A response, then, is in order to help combat these mental health and depression trends. Health communication and campaigns provide one such potential solution. Health communication focuses not only on the traditional topics of the field - the relationship between communication and the maintenance of health and prevention of disease (Freimuth, Edgar, & Fitzpatrick, 1993) - but also looks to position health communication within the larger context of a society significantly influenced by mass media, address media strategies for effective campaigns, and analyze how culture impacts perceptions of health issues (Ratzan, 1996).

Health communication involves researching and participating in interactions between public, private, and volunteer organizations and activities, as well as studying and serving as advocates who synthesize factual, demographic, marketing, psychological, and behavioral information (Beato & Telfer, 2010). Health communicator advocates and practitioners are largely called upon to spread knowledge and awareness, influence attitudes and behaviors, demonstrate healthy practices, and debunk misconceptions (Freimuth, 2004). Despite the rather straight-forward intentions of health communication and promotion, the area of research most often undertaken concerns incredibly large disparities between education and transformation. Health messages inform their publics, but at times can struggle to overcome obstacles in the way of persuading the same publics to actually alter health behavior.

To combat barriers preventing positive health behaviors, health communication advocates often organize campaigns, which are widely used and often considered to be the most effective promotional methodology (Parvis, 2002). Health campaigns are a relatively new scholarly effort, starting four decades ago at Stanford University with a study on heart disease prevention messages and leading to the formation of a health communication office by the Center for Disease Control and Prevention (CDC), which laid the foundation for almost all future health communication campaigns. The CDC model has been used in a variety of health communication campaigns, including awareness about issues like AIDS, drugs, seat belts, and drunk driving (Ratzan, 1996). Health communication campaigns reach desired small and short-term effects of increasing awareness and decreasing misconceptions about health (GreenMills et al., 2013; Snyder, 2002).

In a comprehensive review of the published literature about prevention and intervention mental health campaigns aimed at students enrolled in institutes of higher education, Reavley and Jorm (2010) found – along with the fact that there seems to be relatively little published work on university campaigns – that individual-level campaigns aimed at depression and anxiety typically took the form of cognitive-behavioral theory-based (CBT) interventions, online support groups, and/or educational/personal feedback interventions. Researchers have also documented the nature and effects of international mental health campaigns. A comprehensive literature review of campaigns across 18 countries in the European Union reported that most programs attempted to target the population as a whole, though many segment audiences into targeted groups based on characteristics or settings, and most are focused on improving mental health literacy, although typical strategies also included destigmatization, reducing discrimination, and promoting help-seeking (Quinn et al., 2013).

In response to these factors, this thesis will move towards a more in-depth examination of depression, communication, and stigma by studying related issues, variables, and theories before conducting formative quantitative and qualitative research. That work will serve to inform the creation of relevant campaign materials aimed at decreasing depression treatment disparities on a university campus.

Chapter 2 will investigate variables of depression and depression stigma – both personal and perceived – as well as the practices of mental health and depression campaigns. Personal stigma indicates individual attitudes about a particular stigmatized issue, while perceived stigma indicates how an individual thinks and predicts the attitudes of “most people” (Griffiths, Christensen, & Jorm, 2008). These components will point

toward the application of particular health communication theories and the development of research questions and hypotheses. Guiding theories will include the Theory of Planned Behavior and the Health Belief Model.

Extending from the theory of reasoned action (TRA), the TPB attempts to predict behavior by conceptualizing action as predicted by intentions, which are constituted by beliefs about attitudes, subjective norms, and perceptions of behavioral control, a concept not found in the original TRA (Ajzen, 1991). Inspired by Bandura's (1991) Social Cognitive Theory, perceived behavioral control is understood to vary from the concept of locus of control, which is a stable belief, in its situationally-dependent nature, which is specific to a particular action in a particular context (Ajzen, 1991).

The HBM theorizes that people make health decisions based on their behavioral-antecedent perceptions of susceptibility, severity, benefits, barriers, cues to action, and self-efficacy. Susceptibility and severity need to be perceived as high for an individual to alter behavior (Dutta-Bergman, 2005). The HBM is useful in studying the "risky" behaviors and non-behaviors individuals partake in such as smoking, unprotected sexual behavior, and refusing to seek or accept health treatments (NCI, 2005). The HBM can also be prescriptive, offering general responsive approaches including communicative attempts to increase perceptions of susceptibility and severity, to decrease perceptions of barriers, and/or to increase perceptions of benefits (Henshaw & Freedman-Doan, 2009).

Chapter 3 will then discuss the application of quantitative and qualitative methodologies, involving the adaptation of health communication measurement scales. This chapter will also report participant information, the distribution of surveys, the conduction of focus groups, and the analysis of quantitative and qualitative data.

Chapter 4 will discuss the findings, highlighting key results, and present campaign materials created from the findings. Chapter 5 will explain the implications of this thesis and potential aims for future investigations.

CHAPTER 2: LITERATURE REVIEW

Caused by genetic, biological, environmental, and psychological determinant factors, major depression involves feelings which interfere with an individual's ability to live out and enjoy the various aspects of life (NIMH, 2014). Depressive disorders are common, affecting 10% of adults (CDC, 2012) and 30% of college students (ACHA, 2012). However, only half of Americans who experience an episode of major depression receive treatment (NAMI, 2014) and only 24% of students diagnosed with depression seek treatment (Hunt & Eisenberg, 2010). Moreover, almost 40% of people report being unwilling to communicate with persons suffering with major depression (Pescosolido et al., 2000). Communication researchers have investigated the communicative realities faced by college students, concerning talking about depression, particularly among social groups (Aseltine, Gore, & Colten, 1994; Wright, King, & Rosenberg, 2014; Wright, Rosenberg, Egbert, Ploeger, Bernard, & King, 2013)

Communication and Depression

Scholars have found that interpersonal communication can contribute to the exposure and effectiveness of health messages (Hornik, 1989; Silk, Atkin, & Salmon, 2011). These social connections can have a positive influence, because interpersonal relationships can not only offer support, but can also serve as additional channels for persuasion toward health goals (Adelman, Parks, & Albrecht, 1987). Generally, social support is understood to have a positive impact on those with depression, potentially even decreasing levels of depression (Aseltine, Gore, & Colten, 1994). However, the effects of social support on depression can depend largely on preceding personality factors, such as social competencies and self-conceptualizations. Individuals with higher communication

competence in computer-mediated communication and face-to-face communication report higher satisfaction with their social support and record lower levels of depression (Wright et al., 2013). Wright and colleagues' (2013) findings support previous findings that there are significant, negative relationships between depression and social competencies and depression and self-efficacy (Jones, Hobbs, & Hockenbury, 1982; Kreps, 1988; Wei, Russell, & Zakalik, 2005). Despite the ever-increasing influence of online social networking, face-to-face communication competency has stronger predictive ability about depression (Wright et al., 2013). Thus, as influenced by social competencies, an individuals' interpersonal engagement with members of social support networks can have significant influences on depression.

In addition to social competencies, depression is also linked to an individual's self-concept, which adds an additional layer of complexity to the effects of social support on depression. Wright, King, and Rosenberg (2014) theorized that people do not seek social partners to build them up; rather in an attempt to gain stabilizing effects of predictability and control, individuals will choose interpersonal connections which will confirm or verify their self-conception Supportive feedback that contradicts one's self-concept may be undesired and even threatening (Swann & Predmore, 1985), if not outright negatively influential on health or quality of life (Dakof & Taylor, 1990; Dunkel-Schetter & Wortman, 1982). This perhaps explains why self-verification – the confirmation of self from social partners – has been found to mediate the relationship between social support (both appraisals and satisfaction with those appraisals) and variables of depression, loneliness, and stress (Wright, King, & Rosenberg, 2014).

To understand messages from social networks and the reception of those messages by those with depression, researchers have investigated responses to the disclosures of individuals with depression about their mental health, finding that depression disclosures elicited responses that were expressive, conventional, and rhetorical (Scott, Caughlin, Donovan-Kicken, & Mikucki-Enyart, 2013). Conventional messages, which involved socially normative content and structure, were the most common response, typically following depression disclosures which communicated that the individual with depression was balanced in his or her coping or explicitly asked for support. Expressive messages were the second most common response, which emphasized the responders' own thoughts and feelings and usually followed depression disclosures which suggested that the individual with depression was successfully coping with their mental health issues. Rhetorical messages, which were goal-oriented, were the least common response. Rhetorical messages attempted to redefine the situation, focusing on identities and relationships. These messages were connected to depression disclosures that depicted the individual with mental health as coping poorly with his or her depression. Subsequent evaluations of disclosure responses by individuals with depression suggested that expressive messages were the least supportive, followed by conventional methods, with the rare rhetorical responses as the most supportive (Scott et al., 2013).

Social competencies and self-conceptions can influence the disclosures and communications made by those with depression (Wright et al., 2013; Wright, King, & Rosenberg, 2014), which in turn, can impact social partner responses (Scott et al., 2013). Those responses then determine perceptions of social support (Scott et al., 2013), which

can influence health and levels of depression (Aseltine, Gore, & Colten, 1994; Dakof & Taylor, 1990; Dunkel-Schetter & Wortman, 1982). Intentions to communicate with a friend suffering from depression are influenced by self-efficacy, response-efficacy, perceived severity, perceived knowledge, emotional challenge, and empathy (Egbert, Miraldi, & Murniadi, 2014; Rossetto, Lannutti, & Smith, 2014). The communicative contributions of those within the social network of someone with depression are not solely determined by disclosure; misconceptions about the causes of depressive symptoms, fears of stigma, and fears of offense or rejection have been found to inhibit intentions to intervene in the lives of social partners with depression (Dubovsky, Davies, & Dubovsky, 2004; Epstein et al., 2010). Finally, intervention based health campaigns can also impact the communication of those with depression. Typical public service announcements emphasize responsibility – telling those with depression that they are not to blame – and treatment availability – informing those with depression that they can pursue options for getting better (Lienemann, Siegel, & Crano, 2013). However, just as positively intended interpersonal communications can have negative impacts on those with depression, so too can health promotion messages “boomerang”, having the opposite of their intended effects (Harris, Pierce, & Bargh, 2013). Mental health campaigns meant to destigmatize cognitive disorders have noticed moderate discrimination boomerang effects (Henderson & Thornicroft, 2013). While viewing ads about depression, individuals with depression reported the ads contributing to greater levels of self-stigma, which then mediates the relationship between depressive symptoms and help-seeking intentions (Lienemann, Siegel, & Crano, 2013). Depression campaigns must then exercise caution when developing and distributing promotion materials.

Communication and Stigma

Stigma is an active and socially created and guided process which disqualifies individuals and groups from full social acceptance (Goffman, 1963). The categorization of individuals into particular social identity groups based on perceptions of certain characteristics creates assumptive settings, transformed by society into normative expectations and demands (Goffman, 1963). These are subtle, even subconscious mandates, which when unfulfilled are explicitly brought to the surface of our attention. Such a phenomenon leads to characterizations of individuals which are more virtual than actual (Goffman, 1963). That is to say, society can force upon people identities which more socially constructed as an effect of retrospectively realized nonconformity than may be present in a reality outside of social construction (Goffman, 1963). Stigma occurs when differences from norms are thought by society to be bad, dangerous, weak, or otherwise undesirable. Stigma demonstrates a discrepancy between actual and virtual identities and lead to a significant discrediting of those with atypical qualities (Goffman, 1963).

Stigmatizing attributes may involve physical abnormalities, moral characteristics of belief or behavior, and social constructs such as race or religion (Goffman, 1963). Other researchers have examined the “taint” or demarcation of stigmatized work. Physical taint is associated with unpleasant ideas or thought to be performed under undesirable conditions, social taint involves contact with other stigmatized individuals or the appearance of submission or servitude, and moral taint occurs when goals or methods are thought to defy virtue or civility (Ashforth & Kreiner, 1999). Aspects of each might be observed with the stigma of depression. Depressed individuals often isolate

themselves, providing a physical cue of difference, while depression is thought of as abnormal in society, indicating a social construct worthy of stigma. Finally, depression is often associated with dark, violent thoughts, casting those with the mental illness as having morally depraved minds. Such distinctions between the types of stigma and the extent to which those indicators are on display in any one individual may, in part, determine if those possessing the stigmatizing attribute are immediately recognized and discredited or if they are not immediately perceived but still discreditable if discovered. The former are forced into their discredit, while the latter have avenues of managing undisclosed discrediting information, potentially choosing to “pass” as normal, with various subsequent identity and social outcomes (Goffman, 1963).

Essentially, those with a stigma are not seen to be entirely human and are discriminated against on the basis of a socially developed theory of characteristic inferiority by a majority which is attempting to account for the presumably negative sources of the stigma, such as immorality, and also the presumably negative outcomes of the stigma, such as dangerousness (Goffman, 1963). It is an additional expectation that the stigmatized both realize and maintain the same beliefs about their condition as the “normals,” or those who do not possess the stigmatizing trait. For example, those with depression may be blamed for their mental health condition and fears that those with depression are violent could create social distance between them and normals. It would be similarly expected that depressed individuals share the assumptions of the majority about the sources and effects of their depression.

Yet despite the powerful influence of social categorization, it should not be assumed that individuals automatically accept the normals’ stigma ideologies. In fact,

many among the stigmatized develop an untarnished self-concept, and see discriminators as those who are not quite human. However, Goffman (1963) argued that “systems of honour” (p. 17) are uncommon, making shaming, victimization, and self-hate likely effects. Contact with normals can only serve as a mirroring reminder of defiling difference, potentially increasing uncertainty in identity, interpersonal interaction, and social placement, particularly for those already discredited. Thus, formations of various identity conceptualizations – social, personal, and ego – can influence the ways in which individuals respond to stigma, including ambivalence, professional presentations, and in-group and out-group alignments (Goffman, 1963).

The stigmatized individual can thus influence and be influenced by interpersonal interactions, but a partner in social encounters can be influential as well. Engaging with other members of one’s own stigmatized group can often lead to the creation of subcultures in which the “own” develop symbols and norms (Goffman, 1963). This can help to organize a life of stigma, but necessitates a resignation to the society’s discredit and the assumptions accompanying such disqualification. Meanwhile, normals can certainly be dogmatic – purposeful and unintentional – perpetrators of stigma, but can also be sympathizers who wisely sympathize with the stigmatized. The “wise” may find themselves supportive for a variety of reasons and can often serve as intermediaries between the normals and the own (Goffman, 1963). Using a latent class analysis, Smith (2012) sought to empirically test the traditional stigma-related taxonomy of individuals as the own, the wise, and the normals with a latent class analysis. The study supported the categorization of the own and the normal, but found evidence to differentiate the wise into two nuanced classifications: active and passive (Smith, 2012). The empathetic wise

are distinguished between those who encourage education and the active confrontation of stigma and those who are more passive supporters. Each type of wise can have a positive influence in working toward forms of destigmatization, but each also carries potential risks. Active wise have to be wary of creating psychological reactance among normals, who upon experiencing the zeal of active wise only dogmatically, dig their assumptive heels into the ideological ground rather than consider an empathic reevaluation of their discrediting beliefs and actions. In contrast, a possible pitfall for passive wise is that their inaction may very well be perceived by the normals as suggesting that the wise are in fact in acceptance and support a particular stigma (Smith, 2012).

With an overview of what stigma is and the involved agents, the discussion can now move to consider why and how the process of stigmatization occurs. Concerning the “why,” dispositional explanations are insufficient, as individual characteristics are not the sole determinants of schemas or stereotypes (the cognitive ancestor and predecessor, respectively, to stigma), while cultural determinism fails to account for stigma as a historical, worldwide, and non-human specific phenomenon (Smith, 2007a). Rather, a sociofunctional perspective recognizes that as humans evolved into interdependent, social creatures, it became important to detect and separate from group members who may pose threats to group functioning and living, both physical and social. Stigma, thus, functions both to evaluate social benefits and risks of group membership and to express values and preserve group integrity. Therefore, the marking, isolating, and degrading of those with stigma occurs as an evolutionary method of attempting to order and protect one’s community. The sharing and group-norming of stigma evaluations and expressions occurs through communication (Smith, 2007a).

Concerning the “how” of stigmatization, Smith (2007a) introduces a useful Model of Stigma Communication (MSC). The MSC first posits that stigma messages involves content cues which mark individuals as demonstrating some type of difference from societal norms. Once recognized, stigma messages categorize distinguished people as comprising a social entity dissimilar from the cultural majority and link this identified group to physical and social peril. Finally, stigma messages imply that the discredited class has some sort of responsibility for the danger to which they have been connected, typically suggesting their stigmatized condition is a choice stemming from some form of immorality. Taken together, these content cues catalyze affective reactions from normals, such as negative emotions of disgust, fear, and anger, as well as behavioral responses like ostracization, dehumanization, and discrimination. Interpersonally among normals, stigma messages seem to lend themselves to dissemination, as they validate biases, increase feelings of solidarity, and reinforce differentiation from undesirables (Smith, 2007a).

Smith (2007a) affirmed much of Goffman’s (1963) thoughts on the effects of stigma messages, in that the messages have been found to lead the stigmatized to self-isolate, feel lonely, fear rejection, experience strain interacting with potential stigmatizes, search for compensation strategies, avoid certain situations, and make social comparisons. Such direct effects can lead to harmful indirect outcomes of decreased psychological and physical health (Smith, 2007a). Stigma messages can affect unmarked normals as well, plaguing those seen to be close to the stigmatized with “courtesy stigma,” especially when in proximity to communicable stigma traits, such as HIV. Finally, stigma messages can lead to increased support among normals for more official,

structural discrimination through mandatory detection, public disclosure, and quarantine of the stigmatized (Smith, 2007a).

Stigma messages are not just transferred interpersonally, but disseminated through mass media, as well. For example, presentations in print media of stigmatized health issues have been shown to depict stigma message content cues (marking, categorizing, linking to peril, and attributing responsibility) and expressions of shame and disgust (Smith, 2007b). These messages do not focus on research or treatment and are not generally targeted toward those who have stigmatized illnesses, continuing the marginalization of individuals with stigmatized issues. Stigmatized health issues, like depression, are most often communicated through brochures and posters from nonprofit and government organizations and are depicted separately and differently from challenging (but not stigmatized) health issues, like heart disease, which most often found in magazine advertisements and articles (Smith, 2007b).

In response to stigma, Smith (2011) found destigmatizing interventions typically involve one of three communicative processes. Protests are common, but are largely ineffective as they can lead to significant psychological reactance. Education is the most popular strategy, having been proven to be effective in the short-term, although predictors and long-term consequences are in need of research. Contact, involving opportunities for members of a majority population to actually get to know those who have been stigmatized, is theoretically the most effective tactic to achieve attitudinal and behavioral changes; however, questions remain about practicality and outcomes need further empirical investigation (Smith, 2011).

Willingness to Communicate

Willingness to Communicate (WTC) was first introduced in the 1980s as a distinct, personality-based communication competency trait which describes how inclined an individual is to engage in communication (McCroskey & Baer, 1985; McCroskey & Richmond, 1987). The willingness construct evolved from a number of previous conceptualizations regarding communication likelihood predispositions and has now been developed into a dynamic concept with its own observed determinants and effects (McCroskey & Baer, 1985; McCroskey & Richmond, 1987).

Communication competencies. Preceding willingness to communicate was the similar concept of unwillingness to communicate, attempting to understand individuals' chronic tendencies "to avoid and/or devalue oral communication" (Burgoon, 1976, p. 60). Unwillingness was conceived in an attempt to explain and predict communicative behavior, and its relevant scale measured attitudes toward communication in general, attitudes toward communication in specific situations, and reported behaviors in communication contexts (Burgoon, 1976). The Unwillingness to Communicate scale includes two factors (Burgoon & Burgoon, 1974): (1) rewards, such as trust, social connections, utility, and value, and (2) approach-avoidance orientations, involving anxiety, introversion, and reported frequency of communications. Unwillingness was theorized to negatively correlate with self-esteem and positively correlate with determinants of anomia and alienation, introversion, and communication apprehension and reticence (Burgoon, 1976). Observing that the amount of individual communication is frequently consistent across social situations, Mortensen, Arntson, and Lustig (1977) went even further in describing communication inclinations as characteristic

predisposition, influenced by and a part of individual personality. They subsequently created a more developed scale in which communication disinclination (unwillingness) was only one factor of many which culminated in a global verbal predisposition score (Mortensen, Arntson, & Lustig, 1977).

Concurrently, Phillips (1968, 1984) developed the notion of communication reticence, or communication avoidance. Reticence was understood to be reached when “anxiety about participation in oral communication outweighs [one’s] projection of gain from the situation” (Phillips, 1968, p. 40). In other words, the proclivity to speak in a given situation is the result of a balance between gain and loss; reticence is when “people avoid communication because they believe they will lose more by talking than by remaining silent” (Phillips, 1984, p. 52). Reticence was considered a general avoidance of communication across people and circumstances, one which hinted at distinctions between reticence as a personality trait and reticence catalyzed as the result of situational context. Thus, reticence suggested that communication avoidance may be a personality characteristic, but could also emerge in contextual instances in which loss was perceived to outweigh gain. However, the concept was limited by the vagueness of its global condition without development of specific causation.

Communication apprehension. This led McCroskey to reflect that “the work of Phillips suggests a broadly based anxiety related to oral communication rather than a variety of ‘types’ of communication-bound anxiety” (1970, p. 270). He labeled the phenomenon “communication apprehension” (CA), operationally defined as “*an individual’s level of fear or anxiety associated with either real or anticipated communication with another person or persons* [emphasis in original]” (McCroskey,

1977, p. 78). Thus, reticence is more of a global trait construct which leads persons to characteristically tend towards silence over communication participation, unwillingness to communicate is a global predisposition to avoid experiences of communication, and CA is best understood as a “subconstruct” of such larger notions of communication inclinations (McCroskey, 1977, p. 79), which more specifically focuses on fear and anxiety as root causes. Although other names for CA (audience sensitivity, etc.) were common at the time, McCroskey (1977) saw label differences as more a function of academia than theoretical or empirical distinctions and attempted to consolidate similar efforts under a common umbrella of communication apprehension.

Through the development of measurements of Personal Reports of CA for various ages and concerning a variety of interpersonal, small group, and public speaking contexts (McCroskey, 1970), researchers have examined and described a number of variables which correlate with CA, as well as observed effects of the construct. CA is significantly associated with variables of introversion, self-esteem, self-acceptance, verbal reticence, and general personality (McCroskey, 1978). Although the only sure effect of CA is an internal experience of discomfort (McCroskey & Richmond, 1987), three secondary effects of CA have been described (McCroskey, 1977): (1) Those who experience high CA will withdraw from and seek to avoid communication, (2) those with high CA who have reduced communications will be perceived in a less positive light than those with low CA and greater communication involvement, and (3) withdrawal, avoidance, and negative perceptions can have adverse economic, academic, political, and social effects on those with high CA.

Willingness to communicate. CA as a construct continued to gather empirical evidence, but the larger communication inclination concept to which it was connected remained ambiguous. The same became apparent with the verbal predisposition perspective, with results indicating that only one factor of unwillingness was empirically supported (McCroskey & Richmond, 19887). Reframing Burgoon's unwillingness into communicate into willingness to communicate (WTC), researchers (McCroskey & Baer, 1985; McCroskey & Richmond, 1987) subsequently assumed a new "personality-based, traitlike predisposition which is relatively consistent across a variety of communication contexts and types of receivers" (McCroskey & Richmond, 1987, p. 134). The construct includes considerations of communications which occur in a variety of context factors (in public, in meetings, in groups, and in dyads), as well as with various receiver factors (with strangers, with acquaintances, and with friends). Context factors have been proven to be predictive of one another, as have receiver factors, and each factor correlates with the overall scale, indicating a high degree of reliability and validity (McCroskey 1992; McCroskey & Baer, 1985).

WTC causes and effects. Antecedents to WTC include introversion, anomie and alienation, self-esteem, cultural divergence, communication skill, and – most influentially – CA (McCroskey & Richmond, 1987). Whether attributed to personality trait or context state, CA is consistently shown to be a predictor of WTC overall, WTC with various receivers, and WTC in various social situations (McCroskey & Richmond, 1987; Barraclough, Christophel, & McCroskey, 1988; MacIntyre, 1994; Roach, 1999; Donovan & MacIntyre, 2004). Using the Theory of Planned Behavior (TPB) as a conceptual framework for understanding the interaction of personal traits as they relate to behavioral

inclinations, MacIntyre (1994) conducted a causal analysis of WTC, finding that WTC is caused by a combination of CA and perceived competence (PC) in communication, which have roots in introversion and self-esteem. Individuals will report greater WTC to the extent they are not anxious and think themselves capable of effectively communicating. Thus, the most willing individuals will be fearless and have high self-efficacy, while the least willing will be anxious and perceive themselves to be incompetent. MacIntyre (1994) further illustrates that high CA is caused by high introversion and low self-esteem and that high PC is caused by low introversion and low CA, creating an interconnected model of personal trait variables. The model assumes that individuals have the free choice to communicate and that sources of influence are personality-based, which does not allow the model to explain why unwillingness could lead to negative outcomes, as those are likely also influenced by social factors and processes (MacIntyre, 1994).

To clarify, there are distinct theoretical and empirical differences between CA, WTC, and concepts such as shyness. CA involves fear and/or anxiety about communication, WTC is the orientation to initiate communication, and shyness is the communication behavior of reducing talking (McCroskey, 1978). However, WTC effects reflect CA effects; WTC can influence communication effectiveness and the perceptions of others in academic, organizational, and social contexts (McCroskey & Richmond, 1987), which makes sense given CA's antecedent relationship with WTC. In particular, in examining the negative individual and organization impacts of low WTC, Richmond and Roach (1992) found that those who are perceived to have greater WTC are also

perceived to be more credible, more attractive, more likely to be potential opinion leaders, and subsequently, more likely to hold greater interpersonal influence.

The antecedents and effects of WTC are present in both males and females across ages, but can interact in varying ways. Donovan and MacIntyre (2004) found that junior high school females actually reported higher WTC scores than junior high males, which the authors postulated could be due to stereotypical norms of girls talking and boys playing. However, at the university level, males and females report similar WTC scores, and females then report higher CA and lower PC than their male counterparts. Donovan and MacIntyre (2004) suggested this is due to greater exposure at an older age to the masculine-privileged culture of the United States, but also commented that, as their study stopped at university ages, older populations should be studied to provide further information as to these sex discrepancies. Despite score differences, variables relationships remain largely the same, as CA and PC have a consistent negative relationship across age and sex, PC is a significant predictor of WTC across age for males, and CA is a significant predictor of WTC across age for females (Donovan & MacIntyre, 2004). Why differences in age exist is an essential area in need of further study, but preliminary consistencies of relationships suggest a certain level of WTC generalizability.

WTC and culture. WTC has not been examined in an American vacuum; cross-cultural studies have also been conducted and have further suggested the generalizability of WTC. Typically, the United States is found to have higher WTC scores than other countries (Barracough, Christophel, & McCroskey, 1988; McCroskey & Richmond, 1990; Sallinen-Kuparinen, McCroskey, & Richmond, 1991), although most countries –

including the United States – rate public speaking as the instance in which they are least willing to communicate and dyad interaction as the instance in which they are the most willing (McCroskey & Richmond, 1990). Similarly, all countries are least willing to communicate with strangers and most willing to communicate with friends (McCroskey & Richmond, 1990). Comparisons of WTC, CA, and PC in communication between nations have also been investigated, demonstrating high degrees of difference in mean scores of WTC and PC, but nevertheless substantial similarity in variable relationships (Barracough, Christophel, & McCroskey, 1988). That is to say, while cultures scored differently on the scales of measurement, WTC was significantly associated with low CA and high PC throughout cultures, indicating that such WTC connections are generalizable across cultures (Barracough, Christophel, & McCroskey, 1988).

A study of the United States and three other nations – Sweden, Australia, and Micronesia – have supported the notion that WTC is generalizable across cultures. Large differences in general approach-avoidance tendencies suggest cultural differences between nations concerning WTC and that WTC could be at least partially informed in its development by socialization and/or learned experience; however, relationships between variables remain comparable and, thus, potentially generalizable (McCroskey & Richmond, 1990). A comparison between the United States and Finland does complicate variable relationship generalization hopes. While US populations and Finnish populations share similarities in scores of CA and PC, and while US populations are seen to have greater WTC and Finnish populations to be more introverted, the relationships between variables is dissimilar (Sallinen-Kuparinen, McCroskey, & Richmond, 1991). In fact, CA and PC were seen to be much less predictive of WTC for Finnish populations than they

were for US populations, indicating that culture mediates such relationships and that, in Finnish culture, an unwillingness to communicate is predicted by something other than anxiety (Sallinen-Kuparinen, McCroskey, & Richmond, 1991).

Meanwhile, a desire to examine interactions across cultures led Kassing (1997) to develop the Intercultural Willingness to Communicate (IWTC) scale, which used the traditional McCroskey WTC scale as inspiration in offering hypothetical instances of communication to create the scale. Reporting for willingness items such as talking with someone from another country, talking with someone from a culture one knows little about, and talking with someone who speaks English as a second language, the scale is shown to have high validity, producing correlations between IWTC and an individual's number of friends from foreign countries, and between WTC and IWTC. However, the study did not specifically compare intracultural communication with intercultural communication (Kassing, 1997). Moreover, researchers have examined an attitudinal construct referred to as "international posture," which refers to the importance placed on international communication by an individual (Yashima, Zenuk-Nishide, & Shimizu, 2004). They found that among those learning a foreign language, international posture is seen to influence student WTC in a second language, which subsequently influences the frequency of actual communication in the second language (Yashima, Zenuk-Nishide, & Shimizu, 2004). In other words, as more importance is placed on communication, the more willing individuals are to communicate, and the more they actually communicate. Longitudinal studies of language learners indicate that WTC is a dynamic concept, which is multifaceted and can have fluidity over time, changing due to contextual, personal/individual, and linguistic factors (Cao, 2013).

WTC about health. The useful application of WTC as a dynamic predispositional orientation has been clear to researchers in a number of fields, but surprising less so in health communication. A broad Willingness to Communicate about Health (WTCH) scale has been found to relate to McCroskey's willingness to communicate predispositional instrument, as well as to information-seeking behaviors and patient assertiveness (Wright, Frey, & Sopory, 2007). The instrument consists of three factors: willingness to communicate about health with providers, willingness to communicate about health with non-providers (such as family or friends), and willingness to seek and discuss health information and issues (Wright, Frey, & Sopory, 2007). Using the WTCH scale, researchers have found that females report higher levels of WTCH than males (Wright, Frey, & Sopory, 2007) and that WTCH predicts perceived helpfulness of healthcare center sponsored activities, overall satisfaction with care, and information-seeking behaviors with providers, with non-providers, and with media (Wright & Frey, 2008).

Yet, while WTCH in general has been investigated (Wright & Frey, 2008; Wright, Frey, & Sopory, 2007), research concerning willingness to communicate with specific health care providers or about specific health issues is oddly and extremely limited. A few studies have alluded to WTC in examining related communication inclination variables, such as communication anxiety, likelihood, and intentions (at the time, some even referred to their variables as WTC, though present research has demonstrated WTC to be a construct distinct from similar concepts). Researchers found that trait CA was positively related to fear of interacting with a physician (a particular state CA), and that such situational anxiety was negatively related to patient satisfaction

with care and with the physician (Richmond, Heisel, Smith, & McCroskey, 1998). Before McCroskey had proposed his formal WTC model, Wheelless (1984, 1987) was studying female patients' likelihood of discussing various gynecological topics with their physicians. She found that communication likelihood was positively correlated with physician trust and negatively correlated with CA (Wheelless, 1984), and specifically that CA was a significant predictor of communication likelihood (Wheelless, 1987). Female patients were less likely to discuss intimate sexual topics, but those with low CA were more willing to discuss pain during intercourse and partner impotence (Wheelless, 1987). Similarly, studies using the TPB have approached WTC by investigating behavioral intentions of students to communicate about drinking (Neuwirth & Fredrick, 2004) and smoking (Brann & Sutton, 2009), consistently finding attitudes to be predictive, but also producing conflicting results as to the significance of communication intentions' association with other variables of self-efficacy, subjective norms, and response efficacy (Neuwirth & Fredrick, 2004; Brann & Sutton, 2009).

Other health communication studies have attempted to directly measure WTC, but with their own measures – typically ultra-specific, low- and often 1-item measure explicitly asking participants if they would be willing to communicate about a given topic in a given context (preventing component analysis or reliability checks) – rather than any adaptation or revision of traditional WTC instruments. Salmon and Neuwirth (1990) found that individuals have a higher WTC about abortion with a stranger on a bus or airplane when they also have greater perceptions of personal congruency with a perceived national majority. They also found that issue knowledge and personal concern were significantly related to WTC (Salmon & Neuwirth, 1990). Additionally, Crowell (2004)

supported earlier studies connecting actual condom use and willingness to initiate conversations about condoms or requesting condom use when it was observed that there were significant relationships between WTC about condoms, actual communication about condoms, and actual condom use, between WTC about condoms and condom self-efficacy, and between WTC about condoms and assertiveness. Finally, other research has indicated that WTC about clinical trials with a physician was negatively related to intentions to participate (McComas et al., 2010) and that WTC in small groups and in meetings is related to reduced stress for military soldiers (Gilchrist-Petty & Folk, 2014).

The preceding health communication studies have often not explicitly measured WTC, or done so with such ultra-specific and item-minimal instruments that content analysis, reliability checks, and generalizability are unlikely at best. There are, however, a small collection of studies examining WTC about a particular health issues that utilize a multi-item scale. The WTC about Organ Donation scale involves three questions addressing willingness, comfort, and perceived competency in communicating with family members about the issue (Morgan & Miller, 2002). WTC about Organ Donation has been found to significantly relate to knowledge, attitude, and altruism (Morgan & Miller, 2002) and to prior behavioral thought and intent, perceiving related messages as credible, anxiety following message exposure, and uneasiness considering organ donation (Smith, Kopfman, Lindsey, Yoo, & Morrison, 2004).

Other researchers have identified the relationship between psychological reactance and willingness to communicate about organ donation is moderated by family conversation and conformity orientations (Scott & Quick, 2010). Additionally, much of the willingness to communicate about organ donation research has specifically focused

on African Americans (Morgan et al., 2003; Morgan, 2004). African Americans report significantly lower WTC about Organ Donation than European Americans (Morgan et al., 2003) and within African American populations, WTC about Organ Donation is correlated with willingness to become an organ donor, knowledge, attitudes, and favorable social norms (Morgan, 2004). That these few studies encompass all academic publications on willingness to communicate as it relates to specific health topics and contexts reveals an obvious and startling lack of knowledge which calls for further research. The current thesis thus attempts to provide some of that specificity, examining the interplay of willingness to communicate – drawing inspiration from the WTCH scale (Wright, Frey, & Sopory, 2007) and the WTC about Organ Donation scale (Morgan & Miller, 2002) – and stigma factors within a consideration of depression and stigma among university students and how those factors can become integrated into a comprehensive health campaign.

Theoretical Foundations

The major theories in health communication typically stem from an ecological perspective which recognizes individuals are subject to both the impact of multiple levels of personal influence as well as their social environments (Sallis, Owen, & Fisher, 2008; McLeroy, Bibeau, Steckler, & Glanz, 1988). Theories, then, are often organized at individual, interpersonal, and community levels (NCI, 2005). To understand the complex and intersecting variables which occur at each of these levels in examining health behaviors, academic study requires rigorous theoretical models of understanding. The current study will utilize the Health Belief Model and the Theory of Planned Behavior in order to attempt to observe and explain potential relationships between depression stigma

and student willingness to communicate with mental health providers and with their social networks about depression. The Health Belief Model theorizes a number of health-issue related perceptions and realities, including susceptibility, severity, barriers, and benefits. The Theory of Planned Behavior examines the determinants of health behaviors, including attitudes, subjective norms, and perceptions of behavioral control.

Theory of Planned Behavior. Because the Theory of Planned Behavior emerged directly from the Theory of Reasoned Action (TRA), it is important to examine the preceding theory to understand the Theory of Planned Behavior. The TRA proposed that salient information or likelihood beliefs concerning specific action outcomes function to generate behavior intentions, which subsequently predict behavior (Madden, Ellen, & Ajzen, 1992). Beliefs that precede intentions are conceptualized as behavioral beliefs which influence behavioral performance attitudes and normative beliefs which are subjective perceptions of societal standards. Variables outside of the model are assumed to only affect intentions so much as they affect attitudes and norms. Three contextual conditions that are hypothesized to mediate the magnitude of the intention: behavior relationship are specificity correspondence between intention and behavior, stability of intention until behavior enactment, and degree of individual volitional control over behavior (Madden, Ellen, & Ajzen, 1992). However, citing the failure of previous research – which utilized aggregate measures of behavior – to explain behavioral variability or predict specific actions in particular circumstances, Ajzen (1991) proposed the theory of planned behavior (TPB) to help account for behavior-specific factors which influence decision-making. Extending from TRA, TPB attempts to predict behavior by conceptualizing action as predicted by intentions, which are constituted by beliefs about

attitudes, subjective norms, and perceptions of behavioral control – a concept not found in the original TRA.

Health behavior attitudes refer to the extent to which an individual evaluates or appraises the potential behavior favorably or unfavorably (Ajzen, 1991). Attitudes develop from the beliefs individuals have about an issue or behavior, which are formed through associations of those issues or behaviors with other objects, characteristics, or events (Fishbein & Ajzen, 1975). Thus, outcomes – physical, personal, or social – may be associated with particular health behaviors. The favorability of those associative beliefs leads us to automatically and simultaneously acquire particular attitudes about health behaviors (Ajzen, 1991). Therefore, health behaviors evaluated to have positive impacts will contribute to improved attitudes and increased likelihood of behavior enactment, while health behaviors evaluated to have negative impacts will contribute to soured attitudes and decreased behavior intentions. Accordingly, in the present study, it is hypothesized that as individuals come to view depression as a mark of disqualification from normal society, those stigmatized attitudes will lead persons to unfavorable attitudes of engaging in talk about mental health and ultimately decrease their willingness to communicate. If this is the case, then a campaign intending to increase willingness to communicate about depression may be targeted at attitudes of stigma about depression.

In addition to attitudes, the inclination of individuals to engage in a health behavior is also influenced by subjective norms. Subjective norms refer to socially-constructed pressures to engage or not engage in a particular behavior (Ajzen, 1991). Perceived subjective norms of pressure to perform behaviors are influenced by the anticipated likelihood that relevant and important individuals and social groups will

approve or disapprove of a social behavior. This expected likelihood of approval is referred to as normative beliefs. As normative beliefs are estimated to be greater, the more pressurized and powerful is the influence of subjective norms on behavioral intentions. Thus, if it is anticipated that important social factions will strongly disapprove of a health behavior, such as engaging in communication about depression, then subjective norms exert more pressure on an individual and may decrease depression communication willingness. Hence, another potential avenue for a depression campaign may look to influence individuals and social groups to approve more than disapprove of depression-related discussions. A campaign may also attempt to decrease the perception that communication about depression is a disapproved-of notion.

Finally, inspired by Bandura's (1991) Social Cognitive Theory, perceived behavioral control refers to the ease or difficulty an individual perceives in their performance of a particular health behavior (Ajzen, 1991). This perception is a culmination of past experiences and anticipated opportunities and barriers, examined through original thought and through social interactions and the sharing of experiences and perspectives. Perceived behavioral control is understood to vary from the concept of locus of control, which is a stable belief. Rather, behavioral control is situationally-dependent in nature, specific to a particular action in a particular context. It is theorized that there is a positive correlation between perceived behavioral control and action effort (Ajzen, 1991). Therefore, the more individuals consider themselves able and capable of performing a health behavior with some measure of success, then the more inclined they will be to engage in that behavior. So if they perceived themselves to have a high degree of control in successfully engaging in communication about depression, the more willing

they may be to engage in such interactions. With this view, a depression campaign also could look to either encourage individuals that they are capable of such conversations about depression, or provide some level of information or training to actually make individuals more capable of depression communication.

Like willingness to communicate research, studies utilizing the TPB have investigated organ donations inclinations. Such undertakings have suggested a universality of attitudinal determinants, as attitudes toward donation and communication with family significantly predicted donation intention in the United States, Japan, and Korea, influenced in all three countries by factors of spiritual connection and concern (Bresnahan et al., 2007). Similarly, living and nonliving organ donation is associated with favorable attitudes among Hispanics living in the United States (Siegel, Alvaro, Lac, Crano, & Dominick, 2008), who also demonstrate significant predictive connections between perceived behavioral control and intentions to talk with a family member about living donation (Siegel, Alvaro, Hohman, & Maurer, 2011). Cornea donation research has revealed that one's level of issue involvement significantly predicts attitudes, subjective norms, and perceived behavioral control (Bae, 2008; Bae & Kang, 2008). Furthermore, issue involvement is predicted by empathy and sympathy, which can be influenced by exposure to entertainment-education messages about cornea donation (Bae, 2008), suggesting that entertainment-education may be a useful method of addressing the TPB factors to influence behavioral inclinations.

Research into college students' intentions to exercise have suggested that personality variables may serve as antecedents for TPB beliefs, as student strength of self-monitoring and self-esteem can mediate the effects of various attitudes (Wang,

2009). Such work suggests that campaigns could tailor health promotions to target audiences with various personality characteristics. Other health communication research that confirms the ability of the TPB to predict intentions among young adults has also revealed evidence that the TPB can be effectively supplemented with factors such as satisfaction with healthcare providers and environmental constraints (Anderson, Noar, & Rogers, 2013). This again supports the idea that health campaigns may want to use the TPB as a foundation, but expand to include additional considerations. Also, members of an individuals' social support network should also likely be included in campaign messages, as research has observed that parental exposure to messages influences TPB factors and subsequently increases parent inclinations to discuss health topics, the actual occurrence of health conversations, and youths intentions to engage in health behaviors (Huansuriya, Siegel, & Crano, 2014). Therefore, the utilization of another health communication theory with a specific set of variables will help the present thesis to fill in spaces within and between the TPB's rather broad categories of behavior determinants.

Health Belief Model. One of the most widely used individual theories of health communication is the Health Belief Model (HBM), which was created in an attempt to account for the failings of individuals to take part in preventative or treatment behaviors. The HBM theorizes that people make health decisions based on desires to avoid illness or to become well and beliefs about the health outcomes of particular actions (Janz & Becker, 1984). The model thus considers the four behavioral-antecedent, perceived dimensions of susceptibility, severity, benefits, and barriers, each of which are hypothesized to be influenced by demographic, sociopsychological, and structural variables (Janz & Becker, 1984), along with cues to action and self-efficacy.

Perceived susceptibility refers to an individual's personal feelings of vulnerability to a health condition, involving beliefs in general and beliefs concerned with specific illness, as well as beliefs about possibilities and probabilities of illness contraction (Janz & Becker, 1984). Therefore, an individual who does not think they can or will get a disease or does not think they are likely to get a disease will be less inclined to engage in a health behavior. It would follow, then, that students who do not perceived depression as being an issue they are likely to encounter will be less inclined to engage in communication about depression, pointing campaigners to a potential targeting of susceptibility in promotional efforts.

Severity refers to the extent to which an individual evaluates illness contraction as a serious issue, including both medical consequences and social outcomes (Janz & Becker, 1984). Anticipations of pain or stigmatization if an individual were to develop an illness can influence intentions to undertake health behaviors. Perceived harsh severity contributes to action, while minimal perceived severity is associated with lower inclinations to act. Therefore, if one does not think of depression as being a serious illness, they will likely be less inclined to engage in depression communication. Campaigners might then target severity when attempting to encourage communication about depression. They also may target benefits and barriers.

Benefits refer to how effective an individual perceives various available actions to be in reducing the threat or effects of disease or otherwise contributing to greater health (Janz & Becker, 1984). Hence, if one perceives a health behavior to have positive outcomes, they will be more willing to pursue that course of action. Thus, a campaign targeted at encouraging communication about depression might only be effective if

potential participants think that such conversation may have some kind of positive effect. Finally, barriers refer to any perceptions which might impede inclinations toward action (Janz & Becker, 1984). Such barriers may include, though are not limited to, financial expenses, medical side effects, personal, physical, and/or social unpleasantness, inconvenience, and time-consumption. Therefore, deemphasizing or actually decreasing potential barriers to communicating about depression may be worthy goals of a targeted campaign.

Susceptibility and severity are traditionally conceptualized as the most influential factors, both needing to be perceived as markedly high for an individual to alter behavior (Dutta-Bergman, 2005). While they provide the motivation to act, preference for the type of action is theorized to be catalyzed by benefits and barriers. A comprehensive review of past literature in search of model support, significance, generalizability, and application by Janz and Becker (1984) found each of the variables to have empirical support for significance, particularly perceived barriers (89%), susceptibility (81%), and benefits (78%). This finding highlights the importance of each factor of the HBM and challenge traditional theorizations of the HBM by demonstrating barriers to be the most significant factor. Recent research into the predictive variance among the individual variables of the model confirms the complex influence of the determinants, as benefits and barriers have been shown in a meta-study to consistently be the most significant determinants of behavior likelihood (Carpenter, 2010). Again, barriers are particularly highlighted as an essential area of examination and experimentation. Other research has also indicated that health behavior self-efficacy, the conviction one can successfully engage in an action and effectively produce the desired health outcome, is a variable which relates to the four

HBM dimensions, perhaps as an underlying construct or potentially as its own distinct dimension (Rosenstock, Strecher, & Becker, 1988). Thus if an individual believes they are capable of successfully engaging in a particular health behavior to produce the desired outcomes they will be more inclined to engage in that behavior.

The HBM has clear utility; once researchers and practitioners understand the predictors which influence mental health treatment-seeking behaviors, they can create and disseminate messages and texts which address those factors. For example, the HBM has been used to develop campaign themes and materials targeting mothers considering HPV vaccinations for their daughters (Shafer, Cates, Diehl, & Hartmann, 2011). This was done by first determining the extent to which mothers understood the connection between the virus and cervical cancer (susceptibility and severity), understood the potential benefits, and were interested in barriers such as cost, availability and access, and safety (Shafer, Cates, Diehl, & Hartmann, 2011). However, the HBM has been subject to some criticism from Kirscht (1985), who argued that while the HBM could anticipate variables which are linked to the initiation of mental health treatment, there is little evidence to suggest the variables studied by the HBM are significant predictors that an individual will adhere to and complete their treatment. However, the HBM is useful in studying the “risky” behaviors and non-behaviors individuals partake in, such as smoking, unprotected sexual behavior, and refusing to get a flu shot (NCI, 2005). Therefore, campaigners might want to utilize the HBM to guide the development of campaign materials with the understanding that such use may better fit singular considerations of health behavior, and potentially not adherence action over time.

Research has identified a number of moderating variables in the relationship between HBM variables and behavior, including time between belief measurement and behavior and types of behaviors (Carpenter, 2010). Researchers have also noted that perceived severity is not as significant when considering preventative health, such as vaccination, but is more important with sick-role behavior, and propose that variables can subtract from one another, affecting behavior as a different score (Janz & Becker, 1984). Carpenter (2010) concurred, explaining that due to inconsistent variable effects, including susceptibility and severity, the four-variable, direct-effects version of the HBM offers only an obsolete theorization of health behavior predictors. Therefore, current and future work is best situated as focusing on the mediating effects between variables in order to move toward more complex conceptualizations of health beliefs and behaviors (Carpenter, 2010). Thus, in the current thesis, the HBM will be useful in exploring interrelated antecedents to health behaviors by determining the extent to which stigma about depression is a barrier to willingness to communicate, or the extent to which willingness to communicate might contribute to stigma.

Attitudes and subjective norms, as described by the TPB, have the potential to serve as barriers to treatment, as discussed in the HBM literature. To examine depression among students, the present thesis will attempt to examine rates personal stigma, perceived public stigma, and willingness to communicate, and how those variables may interact. The thesis will therefore explore a number of research inquiries:

RQ1: How willing are students to communicate about depression?

RQ1a: How willing are students to communicate with mental healthcare providers?

RQ1b: How willing are students to communicate with their social networks (family and friends) about depression?

RQ2: Do students have stigmatized attitudes about depression?

RQ2a: Do students have personal stigma about depression?

RQ2b: Do students perceive stigma in others about depression?

RQ3: What correlations exist between depression stigma and willingness to communicate about depression?

RQ4: What predictive relationships exist between depression stigma and willingness to communicate about depression?

The thesis will also move towards the initial development of campaign materials intended to foster more frequent and destigmatizing communication about depression, guided by the theoretical foundations previously discussed and formative data from the above research inquiries. Focus group research will subsequently look to address the research question:

RQ5: What are student responses to campaign materials intended to encourage willingness to communicate about depression?

CHAPTER 3: METHODOLOGY

Study of and service in health advocacy has become an important element of health communication research (Beato & Telfer, 2010), spreading knowledge and awareness, influencing attitudes and behaviors, demonstrating healthy practices, and debunking misconceptions (Freimuth, 2004). Health campaigns are considered one of the most effective ways to promote and advocate for various health issues (Parvis, 2002). A public campaign is a purposeful attempt to inform or influence behaviors within a specified period of time by featuring a number of mediated messages in multiple channels to produce benefits to both individuals and society (Atkin & Rice, 2013). In other words, a campaign intends to generate specific outcomes in a number of individuals, within a specified set of time, and through an organized set of communication activities (Noar, 2006). Campaigns can be seen to encompass a rather broad spectrum of promotional activities, dependent on a number of internal and external factors which can positively guide or negatively inhibit the efforts of campaigners.

Valente (2002) described how the best campaign research involves formative, process, and summative evaluations, involving research collected through multiple sources, at multiple points in time, and with multiple replications. The constraints of the current thesis has focused efforts toward the initial formative research of a campaign. Described as “extremely important” (Noar, 2006, p. 24), formative research enables campaigners to understand targeted audiences in terms of relevant issues and message and channel preferences through the conduction and analysis of archival data, surveys, focus groups, and interviews (Noar, 2006). In addition to identifying target audiences and

audience segments, other preproduction goals outlined by Atkin and Freimuth (2013) include specifying relevant behaviors, developing an understanding of audience knowledge, literacy, beliefs, perceptions, attitudes, values, priorities, efficacy, and skill variables, and selecting channels to be used. Moreover, pilot-stage activities aim to develop initial message components and pretest for message attention, comprehension, strengths, weaknesses, relevance, and audience preference (Atkin & Freimuth, 2013; Valente, 2002). There can be no more important element of successful campaigns than understanding the nuanced lived experiences and perspectives of the intended audience and subsequently pilot-testing campaign elements to ensure appropriateness and effectiveness (Noar, 2006).

The formative research of the current campaign involved a survey attempting to measure audience characteristics in order to guide the initial development of campaign ideas and materials, as well as focus groups attempting to provide supplementary information about those attitudes and pretest initial campaign ideas and materials for attention, comprehension, strengths, weaknesses, relevance, and preference. These efforts were guided by two overarching perspectives of campaigning: ecological and social networking (Valente, 2002). Both of these perspectives recognize that health decisions are not determined by personal factors alone, but by one's contextual and social environments (Valente, 2002). Such factors can strongly influence individuals and often serve as powerful antecedents to beliefs, attitudes, and behaviors (Valente, 2002). As such, campaigns must strive to holistically address both the individual and the environments in which they come to opinions and decisions.

The ecological perspective articulates an understanding of individual behavior as best understood within the context of communities, organizations, policies, and societal norms (Valente, 2002). This helps the campaign designer begin to better understand barriers to behavior change that may be instituted by the society to which target audiences belong. This is why the current campaign places such a strong emphasis on stigma, a socially-constructed phenomenon previously shown in Chapter 2 to serve as a barrier to treatment. Formative research guided by the ecological perspective considers individual, interpersonal, institutional, communal, and societal characteristics (Valente, 2002) of those who stigmatize depression and trivialize those with the mental illness. The ecological model is important for the broader context it provides, yet it is a complicated and wide-reaching set of considerations, in need of a narrowing of focus, which the current campaign provides by integrating the social network analysis perspective.

The social network analysis perspective emphasizes the interpersonal dimension included in the ecological perspective. A perspective which targets networks of individuals – friends and family, for example – requires a consideration of the level and type of interpersonal communication (Valente, 2002) about depression. That is to say, studying the ways in which people think and communicate about depression will be paramount in understanding how they come to particular beliefs, attitudes, and subsequent behaviors concerning communication and treatment. Together, the ecological and social network perspectives lead the campaign designer to consider the contextual, and especially the social, influences which impact health behaviors concerning depression. Thus, the Health Belief Model and the Theory of Planned Behavior were used to operationally establish a set of antecedent ecological and social variables,

consisting of attitudes and subjective norms which serve as barriers to health behaviors.

These attitudes and norms were investigated through a survey and focus groups.

Formative research data collection began after receiving Institutional Review Board (IRB) approval (see Appendix A).

Depression Survey

Survey participants. A total of 300 students participated in the survey. After cleaning the data and eliminating participants who did not fully complete the survey, data from 294 students was studied. Participants were undergraduate students identified and recruited from a large, Mid-Atlantic university through the School of Communication Studies' SONA online research databank, pooled primarily from students in the program's general education introductory communication course. The course is required for all students, aiding in the inclusion of a variety of majors and backgrounds. There were significantly more females ($n = 242$) who took the survey than males ($n = 52$), and most participants were 18 ($n = 194$) or 19 ($n = 89$) years old, with only a few participants who were not teenagers ($n = 11$). Respondents were predominantly white/Caucasian ($n = 256$), with some Asian ($n = 13$), Hispanic/Latino ($n = 10$), black/African-American ($n = 9$), and Pacific Islander ($n = 1$) students, and five who reported "Other."

Almost all participants were first-year students ($n = 281$), as second-year ($n = 7$), third-year ($n = 3$), and fourth-year ($n = 3$) students were not as well represented. Similarly, over 95% of students reported being straight/heterosexual ($n = 282$), while ten students were gay, lesbian, or bisexual, and two students reported "Other." The survey also investigated participant experience with mental illness. Most students reported that they had not received a mental illness diagnosis in the past ($n = 244$), some said they had

($n = 39$), and a few were unsure ($n = 11$). Most students reported that they did not have a current mental illness and were seeking treatment ($n = 260$), while 21 students were seeking treatment for a current mental illness and 13 students reported that they were unsure. Finally, a majority of students did not report having a mental illness without treatment seeking ($n = 248$), some students were unsure if they were failing to seek treatment for a mental illness ($n = 36$), and a few students were certain that they had a mental illness for which they were not seeking treatment ($n = 10$).

Survey design. Participation in the study involved the completion of an online survey, which involved demographic information and two main areas of measurement: depression stigma and willingness to communicate. The survey was administered using Qualtrics (see Appendix B for a copy of the survey). To measure the ecological, socially-constructed potential barrier of stigmatized attitudes about depression, participants completed sub-measures of the Depression Stigma Scale (Griffiths et al., 2004). The Depression Stigma Scale is an 18-item, 5-point Likert-type scale through which participants indicated how much they disagreed or agreed with the scale statements (See Appendix B). The Depression Stigma Scale is comprised of two sub-measures: Personal Depression Stigma and Perceived Depression Stigma. The Personal Depression Stigma subscale included nine items concerning participants' own beliefs about depression, such as "People with depression could snap out of it if they wanted", "People with depression are dangerous", and "If I had depression I would not tell anyone". The Perceived Depression Stigma subscale included nine similar items concerning the perceived beliefs of others about depression, such as "Most people believe that depression is a sign of personal weakness", "Most people believe that it is best to avoid people with depression

so that you don't become depressed yourself", and "Most people would not employ someone they knew had been depressed". Higher scores indicate increased personal or perceived depression stigma, while lower scores indicate decreased personal or perceived depression stigma. Both depression stigma sub-measures were found to be reliable, with high Cronbach alpha scores for personal depression stigma ($\alpha = 0.84$) and perceived depression stigma ($\alpha = 0.86$).

Participants also completed a Willingness to Communicate about Depression scale, adapted for the current study from the Willingness to Communicate about Organ Donation scale (Morgan & Miller, 2002). The organ donation scale included three items about individuals' communication with their family, addressing their willingness, comfort, and perceived competency. This scale was adapted in three ways. First, "organ donation" was replaced with "depression". Second, the scale was adapted to include items to investigate willingness to communicate with friends, in order to more comprehensively understand the social networks in which individuals live and interact. Finally, the scale was adapted to include items measuring actual past and anticipated future communication about depression with family and friends, as well as if participants found those communication experiences to be informative and enjoyable. The final Willingness to Communicate about Depression scale is a 14-item, 5-point Likert-type scale through which participants indicated how much they agreed or disagreed with the scale statements (See Appendix B). Items included statements such as "I would be comfortable talking with my friends about depression", "I have talked with my family in the past about depression", and "I consider it informative to talk with my friends about depression". The total Willingness to Communicate about Depression scale was shown to

be reliable with a Cronbach's alpha of 0.86. Dividing the scale between the family and friend items allowed for the examination of two subscales which were both found to be reliable: Willingness to Communicate about Depression with family ($\alpha = 0.82$) and Willingness to Communicate about Depression with friends ($\alpha = 0.81$).

Willingness to communicate was also measured as it relates to mental health providers. A Willingness to Communicate with Mental Health Care Providers scale was adapted for the current study from the Willingness to Communicate about Health scale (Wright, Frey, & Sopory, 2007). Adaptation began with eliminating original items which included communication with non-providers. Remaining items were slightly rephrased, changing provider to mental health providers. Finally, while the original scale addressed comfort and perceived competency, the adaption attempted to establish consistency between survey scales by including items directly addressing willingness and perceptions of communication with mental health care providers as being informative and enjoyable. The Willingness to Communicate with Mental Health Care Providers scale is a 10-item, 5-point Likert scale through which participants indicated how much they agreed or disagreed with the item statements which made up the scale (See Appendix B). Items included statements such as "I am willing to communicate with mental health care providers", "I am quick to make an appointment to talk with a mental health care provider when I'm not feeling well", and "I consider it enjoyable to talk with mental health care providers". The total Willingness to Communicate with Mental Health Care Providers scale was shown to be reliable with a Cronbach's alpha of 0.82. Each of the items making up the scale contributed to its overall reliability. Finally, respondents answered demographic questions about their age, sex, race/ethnicity, sexual orientation,

academic year, and personal experiences with mental illness diagnosis and treatment, including if they had been diagnosed in the past, if they current had a mental illness, and if they were currently seeking treatment (see Appendix B).

Following the closure of the survey online, participants' responses were collected, recorded, and measured for frequencies, means, and other descriptive statistics using SPSS in order to answer RQ1: How willing are students to communicate about depression? and RQ2: Do students have stigmatized attitudes about depression? Pearson's correlations were conducted to answer RQ3: What correlations exist between depression stigma and willingness to communicate about depression? and multiple linear regressions were conducted to answer RQ4: What predictive relationships exist between depression stigma and willingness to communicate about depression? Following analysis of survey data, a first focus group was conducted in order to supplement quantitative findings with emergent themes about depression. Campaign materials were subsequently developed in response to the formative data and tested with a second focus group.

Depression Focus Groups

Focus group participants. As with the survey, participants were undergraduate students identified and recruited from a large, Mid-Atlantic university through the School of Communication Studies' SONA online research databank. Two focus group were conducted; one responding to communication about depression in general and one responding to campaign materials. There were six participants in the first focus group, all of whom were freshman. Five participants were female and one participant was male. Five participants identified as Caucasian and one participant identified as Asian. Five of the participants reported knowing a friend who had experienced a depressive episode.

One participant reported a friend committing suicide following depression. One participant reported personal experience dealing with depression.

The second focus group consisted of five participants, including two males and three females. Two participants were third-years in school, one was a fourth-year, and one student did not disclose her year in school. Four participants identified as Caucasian and one participant identified as Asian. Participants in the second focus group discussion did not explicitly indicate whether or not participants personally experienced or knew a friend who experienced depression.

Focus group design. The first focus group was designed to discuss students' personal and perceived public notions of depression and willingness to communicate about depression and to supplement results from the formative survey. After signing the consent forms, the participants and researcher engaged in a 55-minute conversation. Focus group questions focused on personal and perceive public notions of comfort, willingness, and competency in communicating about depression with peers (See Appendix B for the focus group protocol). Sample items included questions such as "How comfortable are you talking about depression?" "What would make you more or less willing to talk about depression?" and "Do you think other college students know how to talk about depression?" Analysis of the formative survey and first focus group indicated significant connections between stigma and willingness to communicate (results which are described in detail in Chapter 4). Those observed associations led to the development of campaign materials which attempted to use information from the formative research to engage the ecological, social factors which research has supported as serving as barriers to treatment. The campaign materials included three messages,

which were created in a basic form to allow for content and channel adaption. The messages focused on (1) encouraging communication about depression among all college students in order to destigmatize the disorder, (2) attempting to provide guidance on how to engage in communication about depression, and (3) encouraging those with depression to communicate with mental healthcare professionals (See Appendix C for campaign messages).

The second focus group was subsequently intended to discuss students' perceptions of these campaign materials, specifically investigating message attention, comprehension, strengths, weaknesses, relevance, and participant preference (Atkin & Freimuth, 2013; Valente, 2002). After signing the consent forms, the participants and researcher engaged in a 55-minute conversation about what students thought of the campaign materials and how they thought their college peers might respond to the materials. Items included questions such as "What type of media do you think is most effective at reaching college students?" "What do you think about the depression information provided?" and "Would this campaign item encourage you or others to communicate positively about depression?"

Focus group procedure. Focus groups were conducted using a semi-structured, in-depth focus group protocol in which a set of questions and objectives guided the focus group discussion (see Appendix B). However, the process was co-constructed to allow participants to partially control the direction of the conversation (Heyl, 2001). Focus groups began with a discussion and signing of the informed consent forms and ended with a debriefing of the purpose of the study and a reminder that responses are

confidential. Focus groups were recorded with participant permission. Digital recordings of the focus groups were transcribed, resulting in 34 pages of typed, single-spaced pages.

The analysis of both of the focus groups was conducted using an emergent thematic analysis (Glaser & Strauss, 1967). The transcripts of the focus groups were read thoroughly several times in order to gain a holistic understanding of how students conceptualized and engaged in talk about depression and willingness to communicate about depression and to ensure that any subsequently identified themes were rooted in the actual data and discourse (Strauss & Corbin, 1998). Data were interpretively analyzed, using a constant comparative method to open code the data in order to identify potential themes (Strauss & Corbin, 1998). Data were compared throughout the process, leading to the identification of integrated connection and, eventually, of dominant themes, signified by meeting criteria of recurrence, repetition, and forcefulness (Owen, 1984). In Chapter 4's description of results, comments which illustrate themes are provided. Names of participants were replaced with pseudonyms to ensure anonymity and vocal fillers and punctuation were edited to ensure clarity.

CHAPTER 4: RESULTS

Based on previous research, the current study attempted to investigate attitudes and norms which may influence student behaviors about depression. Specifically, the study examined rates of personal stigma, perceived public stigma, willingness to communicate with mental healthcare providers (WTCMHP), willingness to communicate about depression (WTCD), WTCD with family, and WTCD with friends, along with demographic variables. Research questions guiding the study were focused on frequencies of, and associations and relationships between, the stigma and willingness to communicate scales.

Research Question 1

Research Question 1 examined how willing students are to communicate about depression. This was studied by investigating how willing students were to communicate with mental healthcare providers (RQ1a) and how willing students were to communicate with their social networks about depression (RQ1b). Scale frequencies indicated that college students possess rather moderate levels of WTC, with scale responses typically averaging around a value of 3 out of 5 points. But who are they willing to talk to? Abby, a freshman female from the first, formative focus group explained the importance of a “personal” connection when talking about depression:

I don't really share that much about my personal life with other people. There are only a select few who know everything I've been through. And that was hard enough opening up them and stuff and it is just, if someone walked up to me and said do you want to talk about depression, I'd rather talk about something else.

Communicating about depression to a select, intimate few was a dominant theme throughout both focus groups.

Almost every focus group member discussed at some point how closeness with friends would be the strongest predictor of depression conversation comfort and willingness. Abby explained,

If a good friend of mine comes to me and says, ‘Hey, I’m really upset; I’m feeling depressed. Do you want to talk about it? Can I talk to you about it?’ Yeah, I’m all ears. I want to help you in any way I can. But if it’s...

Abby’s comment trailed off, suggesting that any other communication partner would not elicit the same eagerness to discuss depression. Daisy, also in the first focus group, similarly indicated that talking about depression only among close relations was a social norm she anticipates, saying,

I’d be willing to talk about it with anyone, but I wouldn’t expect anyone to come up to me who wanted to talk about it. Like, I wouldn’t expect a stranger to be like, ‘Hey, I’m going through this. Nice to meet you; can you help me?’

This was a sentiment expressed by the second focus group as well. Ivy, for instance, stated if she didn’t know someone, “it would be harder... But it’s easier when it’s on more of a personal level. You know more about them so it’s more comfortable.”

Who intimate others are considered to be is an interesting element of WTCD. Evie, a female freshman from the first focus group who had recently lost a friend to depression-related suicide, suggested that similarity was a strong foundation to closeness.

I would be comfortable with someone at [the university], because you know you’re in a similar space; you guys are all students, so you’re in the same

community. So I guess if you have some type of attachment – it doesn't have to be that you know the person at all, but you know that you're kind of in the same place – then it might be easier to talk to them.

Other participants indicated that communicative norms of disclosure reciprocity would indicate appropriate levels of closeness to talking about depression. In the first focus group, Frankie describe a depression conversation as “a tit-for-tat kind of thing. I know something about you and now you can know something about me.” Becky seconded Frankie's statement and tied it into notions of similarity and privacy:

Nobody wants to be that one person that dumps everything on somebody and you turn around and realize you know nothing about the other person you're completely confiding in... If you don't know anything about that other person, but you're completely confiding in them, who's to say they won't turn around and tell all the stuff you just told them to everyone you know? So yeah, I definitely agree that you have to have some similarity and some reason of being in the same place at the same time, you know, to find each other to talk about it.

Closeness, similarity, reciprocal norms each seem to emerge more frequently in familial and friendship relationships. Participants were most willing to communicate about depression with friends ($M = 3.12$, $SD = 0.74$), followed by communicating about depression with family ($M = 2.99$, $SD = 0.78$) and communicating with mental healthcare providers ($M = 2.99$, $SD = 0.58$). The first focus group reflected this finding; with minimal prompting to distinguish between friends and family, their statements invariably moved toward considerations of their friends, time and again. Carly and Frankie described how depression conversation would have be undertaken with “close friends”

(“really, really close friends,” according to Frankie) and Abby and Becky echoed such sentiments. Evie, and later Carly, said they would try to talk about depression with their larger friend networks.

In light of the first focus group’s trend toward talking almost exclusively about friends, and the survey’s finding that students are more willing to talk to friends than family, the second focus group was asking specifically to consider communication about depression between friends and family, which complicated the issue. Gary, a third year male who was often looked to for direction from the other focus group members, thought his family would “overreact, for the most part in trying to get me help, when that may not be what I really need. My friends may just be an ear, and that’s what I really need – to be listened to.” Haley disagreed, however, on the basis of time and familiarity, saying,

I feel like I’d feel more comfortable talking to my parents if I had depression, because I probably spend the most time with them outside of school, in the whole year. My peers, it just depends on the level of your relationship. I might not feel comfortable talking to someone who’s in my sorority about it, rather than my brother or my parents.

Ivy suggested that distinctions between friends and family begins to become blurred in college; she said, “It’s hard when you come to college. I’ve made close friends, but they have no idea the past 18 years what I’ve gone through. So it’s like my family are my friends back home who know what I’ve gone through, since I was like five.” That family can simultaneously be friends is a unique aspect that suggests the great complexity in comparing friends and family.

Carly, the only focus group member to disclose personal past diagnosis with depression, further emphasized the differences between communicating about depression with friends and communicating with mental healthcare providers, which were demonstrated by the survey. “It was easier for me to talk to my friend about it, than physically sit there with a therapist and try to tell them what was wrong, because they’d try to tell me what to do.” She went on to describe how she thought a therapist might offer wise words, but that those recommendations would be void of substance or transformative practicality. Carly concluded,

It was harder for me to actually talk to someone professionally, who knows what they’re doing, than to just sit down with my best friend and just be like, I feel like this is happening and this is going on. And I know my friends struggle with it too... But they don’t want to talk to someone about it, someone professionally... I think it’s just easier to open up to someone you’re close to than professionally.

The lines between friends and mental healthcare providers are much more clearly drawn in the survey and in the focus groups, as students are much more willing to talk to their friends than they are mental healthcare providers.

To test for differences in WTC scales by demographic variables, statistical analysis was conducted. An independent sample *t*-test for WTC differences by sex was not significant, nor were one-way ANOVAs for race or year in school. To test for differences between sexual orientation, a one-way ANOVA was conducted, which was significant for WTCD with friends $F(2,291) = 4.52, p = .012$. Post-hoc tests revealed the significant difference in WTCD with friends was between straight/heterosexual students ($M = 3.09, SD = 0.73$) and gay/lesbian/bisexual students ($M = 3.77, SD = 0.93$), as shown

in Table 1. Straight/heterosexual students are significantly less willing than gay/lesbian/bisexual students to communicate about depression. No other WTC scales differed by sexual orientation.

Table 1
Means and Standard Deviations of WTC and Depression Stigma Based on Sexual Orientation

		<i>M</i>	<i>SD</i>
WTCMHP	Straight/Heterosexual	2.9887	.58542
	Gay/Lesbian/Bisexual	3.0273	.54047
	Other	2.7727	.32141
WTCD	Straight/Heterosexual	3.0471	.65802
	Gay/Lesbian/Bisexual	3.3286	.56565
	Other	3.0000	.00000
WTCD with Family	Straight/Heterosexual	3.0015	.77533
	Gay/Lesbian/Bisexual	2.8857	1.09171
	Other	2.4286	.20203
WTCD with Friends	Straight/Heterosexual	3.0927	.72765
	Gay/Lesbian/Bisexual	3.7714	.92631
	Other	3.5714	.20203
Personal Depression Stigma	Straight/Heterosexual	2.0185	.61530
	Gay/Lesbian/Bisexual	1.5889	.44767
	Other	1.3333	.31427
Perceived Depression Stigma	Straight/Heterosexual	3.3656	.66463
	Gay/Lesbian/Bisexual	3.4222	.45300
	Other	3.0556	.54997

To test for differences between having past experience with mental illness, a one-way ANOVA was conducted, which was significant for WTCMHP $F(2,291) = 3.71, p = .026$; WTCD $F(2,291) = 4.12, p = .017$; WTCD with family $F(2,291) = 4.43, p = .013$. WTCD with friends did not significantly differ by past experience with mental illness. Post-hoc tests revealed the significant difference in WTCMHP was between those who have been diagnosed with a mental illness by a health provider in the past ($M = 3.22, SD = 0.82$) and those who have not ($M = 2.95, SD = 0.52$), as shown in Table 2. Those who

have been diagnosed with a mental illness by a health provider in the past are significantly more willing to communicate with mental health care providers than those who have no personal experience with diagnosed mental illness.

Post-hoc tests also revealed the significant difference in WTCD was between those who have been diagnosed with a mental illness by a health provider in the past ($M = 3.30$, $SD = 0.81$) and those who have not ($M = 3.03$, $SD = 0.62$), and between those who have been diagnosed with a mental illness by a health provider in the past and those who are unsure of their mental health diagnosis history ($M = 2.76$, $SD = 0.69$), as shown in Table 2. Those who have been diagnosed with a mental illness by a health provider in the past are significantly more willing to communicate about depression than both those who have no personal experience with diagnosed mental illness and those who are unsure of their mental health diagnosis history.

Additionally, post-hoc tests revealed the significant difference in WTCD with family was between those who have been diagnosed with a mental illness by a health provider in the past ($M = 3.32$, $SD = 0.98$) and those who have not ($M = 2.95$, $SD = 0.73$), as shown in Table 2. Those who have been diagnosed with a mental illness by a health provider in the past are significantly more willing to communicate about depression with family than those who have no personal experience with diagnosed mental illness.

Table 2

Means and Standard Deviations of WTC and Depression Stigma Based on Past Mental Illness Diagnosis

		<i>M</i>	<i>SD</i>
WTCMHP	No	2.9508	.52150
	Unsure	3.0000	.69473
	Yes	3.2214	.82343
WTCD	No	3.0307	.61650
	Unsure	2.7597	.69125
	Yes	3.3004	.80682
WTCD with Family	No	2.9526	.72936
	Unsure	2.7403	.95579
	Yes	3.3223	.98306
WTCD with Friends	No	3.1089	.69154
	Unsure	2.7792	.81907
	Yes	3.2784	.97606
Personal Depression Stigma	No	2.0606	.60969
	Unsure	1.9091	.50630
	Yes	1.6410	.56337
Perceived Depression Stigma	No	3.3634	.67009
	Unsure	3.2626	.62711
	Yes	3.4074	.59088

To test for differences by having a current mental illness diagnosis with active treatment seeking, a one-way ANOVA was conducted, which was significant for WTCD $F(2,291) = 3.18, p = .043$. Post-hoc tests revealed the significant difference in WTCD was between those who have a current mental illness diagnosis and are seeking treatment ($M = 3.28, SD = 0.78$) and those who are unsure of their current diagnosis and treatment condition ($M = 2.70, SD = 0.58$), as shown in Table 3. Those who have a current mental illness diagnosis and are seeking treatment are significantly more willing to communicate about depression than those who are unsure of their current diagnosis and treatment condition. No other WTC scales differed by having a current mental illness diagnosis with active treatment seeking.

Table 3
Means and Standard Deviations of WTC and Depression Stigma Based on Current Mental Illness Diagnosis with Active Treatment Seeking

		<i>M</i>	<i>SD</i>
WTCMHP	No	2.9773	.56637
	Unsure	2.9231	.47361
	Yes	3.1688	.79372
WTCD	No	3.0566	.64117
	Unsure	2.6978	.58405
	Yes	3.2755	.77699
WTCD with Family	No	2.9901	.75982
	Unsure	2.6264	.85623
	Yes	3.2653	.97026
WTCD with Friends	No	3.1231	.72404
	Unsure	2.7692	.89697
	Yes	3.2857	.83054
Personal Depression Stigma	No	2.0269	.61921
	Unsure	2.1795	.59237
	Yes	1.5450	.35295
Perceived Depression Stigma	No	3.3444	.67729
	Unsure	3.5897	.34061
	Yes	3.4868	.51096

To test differences related to having a current mental illness diagnosis without active treatment seeking, a one-way ANOVA was conducted, which was significant for WTCMHP $F(2,291) = 5.06, p = .007$ and for WTCD with family $F(2,291) = 4.26, p = .015$. WTCD and WTCD with friends did not have significant differences by having a current mental illness diagnosis without active treatment seeking. Post-hoc tests revealed the significant difference in WTCMHP was between those who did not report having a current mental illness diagnosis without active treatment seeking ($M = 3.03, SD = 0.59$) and those who are unsure of their current diagnosis and treatment condition ($M = 2.70, SD = 0.36$), as shown in Table 4. Those who did not report having a current mental illness diagnosis without active treatment seeking were significantly more willing to

communicate with mental healthcare providers than those who are unsure of their current diagnosis and treatment condition.

Post-hoc tests also revealed the significant difference in WTCD with family was between those who did not report having a current mental illness diagnosis without active treatment seeking ($M = 3.05$, $SD = 0.80$) and those who are unsure of their current diagnosis and treatment condition ($M = 2.67$, $SD = 0.62$), as shown in Table 4. Those who did not report having a current mental illness diagnosis without active treatment seeking were significantly more willing to communicate with family about depression than those who are unsure of their current diagnosis and treatment condition.

Table 4
Means and Standard Deviations of WTC and Depression Stigma Based on Current Mental Illness Diagnosis without Active Treatment Seeking

		<i>M</i>	<i>SD</i>
WTCMHP	No	3.0301	.58753
	Unsure	2.7045	.35799
	Yes	2.9818	.82076
WTCD	No	3.0953	.68390
	Unsure	2.8254	.36399
	Yes	2.9214	.54549
WTCD with Family	No	3.0501	.79713
	Unsure	2.6667	.61847
	Yes	2.7714	.74444
WTCD with Friends	No	3.1406	.74002
	Unsure	2.9841	.66374
	Yes	3.0714	1.05032
Personal Depression Stigma	No	2.0134	.62704
	Unsure	1.9444	.55045
	Yes	1.8444	.56218
Perceived Depression Stigma	No	3.3705	.66956
	Unsure	3.3426	.45880
	Yes	3.3222	.96360

Research Question 2

Research Question 2 asked if students had stigmatized attitudes about depression. This was studied by investigating if students had personal (RQ2a) and/or perceived stigma (RQ2b) about depression. Students were observed to have relatively moderate-to-low levels of depression stigma. Students reported higher perceived stigma ($M = 3.37$, $SD = 0.66$) than personal stigma ($M = 2.0$, $SD = 0.62$). To test if this difference was significant, a t -test was conducted and was in fact significant, $t(293) = -28.70$, $p = .000$. This indicates that students think that others have significantly higher rates of stigma than they themselves report having.

Focus group analysis supports and supplements this quantitative finding, as few participants demonstrated feelings of personal stigma, but perceived stigma was an incredibly prevalent theme in both focus groups, as almost all focus group members indicated that they thought their peers would be unwilling or uncomfortable talking about depression because they had stigmatized attitudes. Daisy described depression as a topic not talked about in “daylight” and said it was perceived to be taboo and abstract. Both Carly and Daisy described how they thought other students would try to “tip-toe” around the issue when confronted with depression. Evie said people in her experience were uninterested. Clearly focus group members did not think too highly of their peers’ stigmas and inclinations to talk about depression, and they offered a number of reasons why they thought stigma was such an influential issue.

Frankie was most vocal in exploring the underlying assumptions of stigma:

I think it kind of goes into the idea that everyone thinks that they need to look like the perfect person. So, if someone comes up to you and is like, ‘Hey, do you want to talk about depression or your personal life?’ you don’t want to tell them stuff

that makes you look not-perfect... I don't want to tell people there was a point in my life where I was completely pathetic... I want to seem perfect.

In the second focus group, Haley indicated that the stigma-creating pursuit of perfection is a product of society. She stated,

Nowadays I feel like everyone is very selfish. It's a 'me' generation... Someone you tell your problems to, they might be like 'okay,' but may not act upon it, which I think is the scary part of the reasons why people don't go to other people for help when they're dealing with depression.

Focus group comments spoke to an individualistic, societally-influenced emphasis on self-perfection that would lead people to avoid talking about a topic which is seen as imperfect. Gary expanded on why avoidance is so intense when he explained that with "any stereotype, you think of the most extreme examples." Gary continued that even if someone with a low level of depression severity were to disclose their depression, their partner in communication would still think of "the worst-case scenario stereotype."

What's wrong with fitting a stereotype of being different? Frankie argued,

A lot of people hear words like depression, anxiety, and I think they tend to think that there's some sort of fundamental problem with someone... Because you see these mental health issues as a fundamental problem with a person, you don't want to talk about it, because it's pointing out faults in people.

Focus group members seemed to suggest, then, that the stigmatized attitudes of their peers meant that other college students assume the worst in those with depression; that other students thought that depressed individuals had a fundamental fault which would render them unable to join in the pursuit of perfection normal to society.

The theme of perceived stigma is all the more exacerbated when specifically considered in the context of the college experience. Both focus groups talked about the college experience as being the best time or best years of a student's life, making depression all the more undesirable a topic. Becky suggested that failing to have an authentic university experience could actually lead to depression. She recounted the experiences of a friend who failed to get the "full college experience, so I guess something in that triggered her to start feeling depressed." Carly and Johnny each expressed a different perspective; that the expectations of experience in college would prevent conversations about depression from happening. Carly stated,

College is supposed to be the 'best years of your life'... So if someone was like, 'Hey I need to talk about depression,' [other students] would be like, 'What are you depressed about? This is the best place on Earth. This is happiest place on Earth. These are the best years of your life. I don't understand.' So I feel like [most college students] probably wouldn't be too comfortable.

Johnny had similar thoughts, putting himself in the shoes of someone wanting to talk about depression. "In college, being the depressed person, it's hard to go up to talk to people," Johnny said,

Because everyone else just wants to have fun and enjoy their college experience. College is one of the best times of your life, and you're depressed; how do you deal with that? Do you tell someone, 'Actually, it's not the best time of my life'?

Clearly, the focus group perceived stigma to be especially prevalent in college settings.

To test for differences by sex, independent sample *t*-tests were conducted. There was a significant difference in personal depression stigma between males ($M = 2.29$, SD

= 0.53) and females ($M = 1.94$, $SD = 0.61$); $t(292) = 3.91$, $p = .000$. Males reported significantly more personal depression stigma than females. To test for differences between age and race, one-way ANOVAs were conducted; these were not significant. To test for differences between year in school, a one-way ANOVA was conducted, which was significant for perceived depression stigma $F(3,290) = 3.22$, $p = .023$. Post-hoc tests revealed the difference was between first year students ($M = 3.39$, $SD = 0.64$) and fourth year students ($M = 2.41$, $SD = 0.80$), as indicated by Table 5. Fourth year students have significantly less perceived depression stigma than first year students. Personal depression stigma did not have differences by year.

Table 5
Means and Standard Deviations of WTC and Depression Stigma Based on Year in School

		<i>M</i>	<i>SD</i>
WTCMHP	First	2.9803	.55955
	Second	3.1169	1.08167
	Third	3.2121	.68232
	Fourth	3.2424	1.23427
WTCD	First	3.0496	.64464
	Second	3.3061	.98519
	Third	2.8810	.71548
	Fourth	3.2857	.84213
WTCD with Family	First	2.9832	.77568
	Second	3.2041	1.07810
	Third	2.8571	.93678
	Fourth	3.6190	.91844
WTCD with Friends	First	3.1159	.72988
	Second	3.4082	1.20495
	Third	2.9048	.50170
	Fourth	2.9524	1.05302
Personal Depression Stigma	First	2.0099	.60904
	Second	1.9841	.83501
	Third	1.5185	.61195
	Fourth	1.5185	.61195
Perceived Depression Stigma	First	3.3879	.63684
	Second	3.0317	1.06519
	Third	3.0000	.61864
	Fourth	2.4074	.80380

To test for differences between sexual orientation, a one-way ANOVA was conducted, which was significant for personal depression stigma $F(2, 291) = 3.60, p = .029$. Post-hoc tests for personal depression stigma revealed a more complex picture, as difference was observed between straight/heterosexual students ($M = 2.02, SD = 0.62$) and gay/lesbian/bisexual students ($M = 1.59, SD = 0.45$), as shown in Table 1. However, although the post-hoc differences approach significance, they were not actually

statistically significant. While straight/heterosexual students report greater personal depression stigma than gay/lesbian/bisexual students, that difference can at this time only be considered moderate, not significant. Perceived depression stigma did not have differences by sexual orientation.

To test for differences between having past experience with mental illness, a one-way ANOVA was conducted, which was significant for personal depression stigma $F(2,291) = 8.33, p = .000$. Post-hoc tests revealed the significant difference in personal depression stigma was between those who have been diagnosed with a mental illness by a health provider in the past ($M = 1.64, SD = 0.56$) and those who have not ($M = 2.06, SD = 0.61$), as shown in Table 2. Those who have been diagnosed with a mental illness by a health provider in the past have significantly less personal depression stigma than those who have no personal experience with diagnosed mental illness. Perceived depression stigma did not have differences by having past experience with mental illness.

To test for differences by having a current mental illness diagnosis with active treatment seeking, a one-way ANOVA was conducted, which was significant for personal depression stigma $F(2,291) = 6.80, p = .001$. Post-hoc tests also revealed the significant difference in personal depression stigma was between those who have a current mental illness diagnosis and are seeking treatment ($M = 1.54, SD = 0.35$) and those who do not have a current mental illness diagnosis or are seeking treatment ($M = 2.03, SD = 0.62$), and between those who have a current mental illness diagnosis and are seeking treatment and those who are unsure of their current diagnosis and treatment condition ($M = 2.18, SD = 0.59$), as shown in Table 3. Those who have a current mental illness diagnosis and are seeking treatment have significantly less personal depression

stigma than both those who do not have a current mental illness diagnosis or are seeking treatment and those who are unsure of their current diagnosis and treatment condition. Perceived depression stigma did not have differences by having a current mental illness diagnosis with active treatment seeking.

To test differences related to having a current mental illness diagnosis without active treatment seeking, a one-way ANOVA was conducted, which was not significant for either personal depression stigma or perceived depression stigma.

Research Question 3

The third research question asked what correlations existed between depression stigma and WTC about depression. To test this, a Pearson's product-moment correlational coefficient was conducted, with results shown in Table 6. There were significant positive correlations between WTCMHP and WTCD $r(292) = 0.41, p = .000$, WTCMHP and WTCD with family $r(292)=0.36, p=.000$, and WTCMHP and WTCD with friends $r(292)=0.35, p=.000$. WTCMHP was negatively correlated with personal depression stigma $r(292)=-0.19, p=.001$. As WTCMHP increases, there are also increases in WTCD, WTCD with family, and WTCD with friends, and decreases in personal depression stigma.

WTCD was also significantly, positively correlated with its subscales, WTCD with family $r(292)=0.87, p=.000$ and WTCD with friends $r(292)=0.85, p=.000$, and negatively correlated with personal depression stigma $r(292)=-0.14, p=.017$. As WTCD increases, there are also increases in WTCD with family and WTCD with friends, and decreases in personal depression stigma. WTCD with family was also significantly, positively correlated with WTCD with friends $r(292)=0.47, p=.000$. As WTCD with

family increases, so too does WTCD with friends. WTCD with friends was also significantly, negatively correlated with personal depression stigma $r(292)=-0.16$, $p=.008$. As WTCD with friends increases, there is a decrease in personal depression stigma. Personal depression stigma was significantly, positively correlated with perceived depression stigma $r(292)=0.18$, $p=.002$. As personal depression stigma increases, so too does perceived depression stigma.

Table 6
Correlations between WTC and Stigma

	WTCMHP	WTCD	WTCD Family	WTCD Friends	Personal Stigma	Perceived Stigma	<i>M</i>	<i>SD</i>
WTCMP	1	.414**	.362**	.346**	-.191**	.046	2.9886	.58170
WTCD		1	.865**	.848**	-.139*	.009	3.0564	.65400
WTCD Family			1	.467**	-.085	-.016	2.9937	.78479
WTCD Friends				1	-.155**	.033	3.1190	.74221
Personal Stigma					1	.178**	1.9992	.61540
Perceived Stigma						1	3.3655	.65707

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Research Question 4

The fourth research question asked what predictive relationships existed between depression stigma and WTC about depression. To test for predictors of WTCMHP, a multiple linear regression was conducted and was significant $R^2 = 0.19$, $F(4,289) = 17.44$, $p = .000$. WTCMHP is significantly, positively predicted by WTCD with family $t = 4.31$, $p = .000$ and WTCD with friends $t = 3.31$, $p = .001$, and negatively with personal depression stigma $t = -2.78$, $p = .006$, as shown in Table 7. If individuals are more willing to communicate with their family and friends and has low personal stigma about

depression, they are more likely to be willing to communicate with mental healthcare providers.

Table 7
Summary of Multiple Regression Analysis for Predictors of WTCMHP

	<i>B</i>	Std. Error
Constant	2.003	.234
WTC with Family	.191	.044
WTC with Friends	.157	.047
Personal Depression	-.143	.051
Stigma		
Perceived Depression	.063	.048
Stigma		
R^2	0.19	
F	17.44*	

* Regression is significant at the $p < .0005$ level.

To test for predictors of WTCD, a multiple linear regression was conducted and was significant $R^2 = 0.18$, $F(3,290) = 20.47$, $p = .000$. WTCD is significantly, positively predicted by WTCMHP $t = 7.36$, $p = .000$, as shown in Table 8. If individuals are more willing to communicate with mental healthcare providers, they are more likely to be willing to communicate about depression with their social network.

Table 8
Summary of Multiple Regression Analysis for Predictors of WTCD

	<i>B</i>	Std. Error
Constant	1.835	.277
WTCMHP	.451	.061
Personal Depression	-.066	.059
Stigma		
Perceived Depression	.001	.054
Stigma		
R^2	0.18	
F	20.47*	

* Regression is significant at the $p < .0005$ level.

To test for predictors of WTCD with family, a multiple linear regression was conducted and was significant $R^2 = 0.27$, $F(4,289) = 26.22$, $p = .000$. WTCD with family is significantly, positively predicted by WTCMHP $t = 4.31$, $p = .000$ and by WTCD with

friends $t = 7.26$, $p = .000$, as shown in Table 9. If individuals are more willing to communicate with mental health care providers and more willing to communicate with their friends about depression, they are more likely to be willing to communicate about depression with their family.

Table 9
Summary of Multiple Regression Analysis for Predictors of WTCD with Family

	<i>B</i>	Std. Error
Constant	.865	.334
WTCMHP	.316	.073
WTCD with Friends	.414	.057
Personal Depression Stigma	.037	.067
Perceived Depression Stigma	-.054	.061
R^2	0.27	
F	26.22*	

* Regression is significant at the $p < .0005$ level.

To test for predictors of WTCD with friends, a multiple linear regression was conducted and was significant $R^2 = 0.51$, $F(4,289) = 25.83$, $p = .000$. WTCD with friends is significantly, positively predicted by WTCMHP $t = 3.31$, $p = .001$, and by WTCD with family $t = 7.26$, $p = .000$, as shown in Table 10. If individuals are more willing to communicate with mental health care providers and more willing to communicate with their family about depression, they are more likely to be willing to communicate about depression with their friends.

Table 10

Summary of Multiple Regression Analysis for Predictors of WTCD with Friends

	<i>B</i>	Std. Error
Constant	1.355	.310
WTCMHP	.233	.070
WTCD with Family	.372	.051
Personal Depression Stigma	-.115	.063
Perceived Depression Stigma	.054	.058
R^2	0.26	
F	25.83*	

* Regression is significant at the $p < .0005$ level.

To test for predictors of personal depression stigma, a multiple linear regression was conducted and was significant $R^2 = 0.08$, $F(4,289) = 6.47$, $p = .000$. Personal depression stigma is significantly, positively predicted by perceived depression stigma $t = 3.38$, $p = .001$, and negatively by WTCMHP $t = -2.78$, $p = .006$, as shown in Table 11. If individuals are less willing to communicate with mental health care providers and highly perceives that others have stigma about depression, they are more likely to have higher personal stigma about depression.

Table 11

Summary of Multiple Regression Analysis for Predictors of Personal Depression Stigma

	<i>B</i>	Std. Error
Constant	2.164	.268
WTCMHP	-.182	.066
WTCD with Family	.028	.052
WTCD with Friends	-.098	.054
Perceived Depression Stigma	.179	.053
R^2	0.08	
F	6.47*	

* Regression is significant at the $p < .0005$ level.

To test for predictors of perceived depression stigma, a multiple linear regression was conducted and was significant $R^2 = 0.04$, $F(4,289) = 3.20$, $p = .014$. Perceived depression stigma is significantly, positively predicted by personal depression stigma $t = 3.38$, $p = .001$, as shown in Table 12. If individuals have high levels of personal stigma about depression, they are more likely to highly perceive that others have stigma about depression as well.

Table 12

Summary of Multiple Regression Analysis for Predictors of Perceived Depression Stigma

	<i>B</i>	Std. Error
Constant	2.632	.284
WTCMHP	.095	.072
WTCD with Family	-.049	.056
WTCD with Friends	.055	.059
Personal Depression Stigma	.212	.063
R^2	0.04	
F	3.20	

* Regression is significant at the $p < .05$ level.

Additional Focus Group Themes

In addition to only communicating about depression with an intimate few and high perceived stigma about depression in others, two additional themes emerged from the focus groups, which contributed to the creation of campaign materials: help-provision desires and perceived public ignorance of depression severity.

Help provision desires. The most common theme concerning focus group members' perceptions of communication about depression was an emphasis that conversations about depression should involve some form of "helping." Daisy even described failing to communicate help those with depression as a "disservice," saying, "I feel as though it's kind of a duty to try to help those that do, because I know that I can kind of help, 'cause I'm in the right frame of mind to attempt to do that." Implicit in

Daisy's statement is the idea that depressed individuals cannot help themselves and need guidance from non-depressed persons. Other students expressed similar perceptions of their own ability to help those with depression. Haley stated, "I'm glad they feel comfortable enough to come talk to me, because I feel like I can help them."

Help provision was observed by the two focus groups in slightly different ways. Encouraging those with depression to seek out further help was common within the first focus group, while a more general provision of advice was expressed in the second focus group. Said Evie in the first focus group,

With my own friends that do have depression, I really try to push for them to get over your pride and get help... Make them see that it's okay to seek counseling or talk to someone about it, instead of just struggling by yourself.

Abby confirmed that if a friend were to disclose depression to her she would be sure to encourage help-seeking, even if not at first.

Obviously I wouldn't just say right after she tells me, 'Oh, I have depression,' like, 'Get help!' In the long run, [I would] make sure she's seeking help, because if she's my friend, I don't want it to get worse.

Participants in the second focus group suggested that disclosures of depression would be made in pursuit of relevant advice. Gary recommended that even if you are uncomfortable, "you need to make it seem like it to the other person that you are comfortable, because they're coming out to you, looking to you for advice." Ivy and Haley suggested listening carefully in order to understand the best advice to give. "See how much they want to disclose to you and then go from there to see how much support or information you should help them with," said Haley, while Ivy stated, "It's hard to

have a structured format, but definitely listening and trying to... give advice.” In contrast, Gary seemed to have an established set of advice packaged and ready to deliver to any depression disclosers:

I give them advice. If they're in a relationship, I tell them they need to think of themselves. They can't think of another person, because if you're depressed, yourself is the most important thing that you should be thinking of.

Carly was the most vocal participant when describing her attempts to help others. She described her own thoughts and actions in detail:

For me I'm passionate about having other people know that this is a struggle that other people go through, and you want to promote more self-awareness and health-awareness about what's going on. This is actually a real thing that people struggle with and you don't have to be some perfect person with this wall up, acting like you have your life together, because not everyone does; most people don't. So I feel passionate about it and have some reason behind talking about it. Being aware, that's my reason for talking about it with people. I want people to get better. I want people to be able to talk about it. Not just sit there. Because I kept my depression to myself for four years before I was like, 'I can't do this anymore.' So I don't want anyone else to go through that. So if you can help change one person's life, that's, like, my thing.

Carly's description was met with enthusiasm from the other focus group members and helped to highlight the compassionate intentions in focus group members' focus on help-provision. It is also a unique response, as she frames the content of her conversations about depression as a broad advocacy for awareness, while most other focus group

members frame the content of depression conversations as providing advice to those with depression. Carly was the only participant to not imply that conversations about depression have to involve those who are depressed; her statement seems to encompass awareness on the part of depressed and not-depressed persons and her advice was simply to learn and talk about it. The help-provision from other focus-group members, on the other hand, was largely oriented toward solution-seeking for depression.

Perceived public ignorance of severity. Carly's statement also reflects a final theme which emerged in the focus groups about depression communication: depression is a serious condition that few people knew a significant amount about. Ignorance of severity was seen to derive from a lack of experience and a lack of education, both complicated by the variety of experience individuals can have with depression. Becky said simply, "I have no idea what that's like," while Evie elaborated,

I wouldn't say that I could be confident in talking about it and know what it really is because it's different for everyone and there's different ways of dealing with it.

So I would just be able to talk about it from general standpoint.

Even the aforementioned help-provisions were guided by the perception of a lack of knowledge. Daisy recommended,

Something to not say – I'm trying to get this phrase out of my vocabulary – 'I know exactly what you're going through. I can totally relate,' because you can't. And no one's past experience are the same. Like, your current experience couldn't be the same.

Focus group members attributed the same inability to fully understand the experience of depression to their college peers as they ascribed to themselves. When

asked if college students knew how to talk about depression, most participants immediately voiced their belief that fellow students did not have effective capabilities.

Becky said,

Probably not the majority. I just feel like there are more people who wouldn't know how to react or what to say or how to just be there... It would just be awkward... So I think a lot of people would just sit there and kind of stare at them, or try to make those blanket statements like, 'It's gonna be okay.'

Frankie affirmed that most college students "have no real experience with it, so they would probably be uncomfortable and not know what to say."

Many focus group participants tied ignorance of seriousness to a lack of education. Daisy stated, "People aren't educated about it enough," while Johnny also emphasized, "Education... about how it works, so you understand how to communicate with the other person." A lack of education was seen to contribute to the failure of students to recognize the detailed nuances of and alternative treatment options for depression. Frankie said,

I think there's just a very skewed understanding of how, not just depression, but mental health in general works... They really don't understand that there is all sorts of backgrounds that lead to these sorts of things. Your history, your environment, your way of thinking. All of that can influence this kind of stuff, and people think the only way you can fix it is to take medication or see a psychiatrist.

In the second focus group, Haley and Ivy both echoed the need for education for the general public, particularly “about what different forms of depression look like,” as Haley put it. She went on to emphasize,

Explaining to people the difference between clinical depression and situational [depression]. You might not even know if someone has depression, [or] if it’s just someone going through something bad at that time.

Ivy agreed,

Knowing about severity is huge. Someone could be about to take their life, and that’s a lot different than someone in the lower stages. And if you weren’t aware of how it works, that could be bad. So I think it’s good to be aware and know background about [depression].

Campaign Materials

In response to a survey findings that students are most willing to talk to their peers about depression and that they perceive fellow college students as having high levels of stigma, and in response to a first focus group that echoed those WTC and stigma themes, as well as introducing additional themes of help-provision desires and perceived public ignorance of severity, initial campaign materials were developed as part of a potential campaign which would attempt to encourage more frequent and more destigmatizing conversations about depression among college students and their peers. Three items were created in a format that would be conducive for use as a traditional poster, but also for additional forms of campaigning such as table-tents, banners, emails, or other digital advertisements. The formatting was relatively basic, as this formative stage of the campaign is interested primarily in concept development before transitioning

to aesthetic considerations. Each campaign item was bracketed by a relevant “hashtag” – a mechanism originating with Twitter which has become part of the cultural zeitgeist – at the top and the hypothetical Twitter handle (or username), @LetsChatJMU, at the bottom. In somewhat smaller text was a definition of depression – “Depression: (1) Emotions that interfere with everyday life in a big way, (2) A common problem” – followed by the intended message of the campaign item (See Appendix C for campaign items).

The first campaign item was intended to make the general student population aware of the relevancy and importance of having conversations about depression with their peers. The hashtag at the top read “#ChatAcceptance” and the main message asked the question, “Why Chat?” followed by three bullet pointed statistics about (1) depression rates among college students – “aka your friends!” – (2) treatment rates of college students with depression, and (3) the rate of suicide among young people. These points were specifically developed in response to observed perceived public stigma and perceptions of public ignorance of severity.

The second campaign item was intended to inform the general student population about how they could go about engaging the conversations about depression with their peers. The hashtag at the top was “#ChatPositive” and the main message read “How to Chat,” followed by three bullet points that encouraged students to seek out knowledge about depression, summon courage, and listen. The knowledge seeking point was followed by a sub-point, which cautioned against perpetuating misinformation, while the courage point was followed by a sub-point which encouraged students that they didn’t have to be comfortable, just willing. These messages were created specifically to respond

to observed moderate levels of willingness to communicate about depression and help-provision desires.

The final campaign item was intended to encourage those with depression to seek out professional help in addition to social network support. The hashtag at the top was “ChatProfessionally” and the main message asked “Why Chat?” followed by three points which equated mental health appointments to doctor and dentist check-ups and provided contact information for the counseling center on campus. These messages were created to specifically respond to the observation that students are less willing to communicate with mental healthcare professionals than their friends.

Research Question 5

The second focus group was provided exposure to the developed campaign items and asked to respond to how they thought they and their peers might react to such materials, as per Research Question 5. A number of useful recommendations were co-created by the participants and the researcher. These recommendations included an emphasis on visually appealing posters and social media outreach. All of the participants thought the campaign items avoided being too “wordy,” but would benefit from the inclusion of some form of relevant imagery and unique placement, such as in stairwells, bathrooms, locker-rooms, and library study spaces. A unique point of improvement was the suggestion that the campaign items should avoid use of the school colors, as students are already inundated with campus sponsored events, to the point that university-related messages are largely ignored. Throughout the discussion, two dominant themes emerged through the ensuing discussion: explicit expression of relevancy and privacy concerns.

Explicit expression of relevancy. When reacting to the campaign items, focus group members emphasized that messages needed to very directly relate to target audiences that the message was relevant to them and their friends. Without explicit relevancy, participants indicated that only those with personal experience would be engaged by the messages. Said Haley,

It depends just how involved you are in the topic... [If] you're not going through a personal situation or know someone's going through a personal situation, [you're] not going to take the time to read it.

Gary agreed, saying,

If I have no background on knowing anybody depressed, I'm gonna be like, 'I don't need this; this doesn't relate to me.' Or, if someone has had friends come out to them [as depressed], they'll be like, 'This has happened before, this is good knowledge to know.'

Therefore, if messages are to be effective in engaging the general public, expressions of relevancy need to be made explicitly clear.

This mandate is where many of the praises and critiques of the campaign items originated from. The focus group participants clearly appreciated the definition of depression, complementing its simplicity, directness, and use of "laymen's terms." Participants also connected strongly with the first point that 30% of college students – aka your friends – may experience depression. Ivy said the statistic was "a good connection point" that would help those with depression realize "other people are going through this just as much as me," while Gary thought that it would be appealing to those without depression, because

It's putting a face on... more than depression-the-illness and now its depression-your-friends. Because you're going to care more about it if you have a person that you're helping, rather than just an illness you're trying to stop.

The second campaign item also received praise based on the explicit relevancy criteria for its specific steps for participating in communication about depression. Johnny believed that it "provides the right type of education," while Ivy liked "how the chat works. So instead of just talking about depression – which is helpful – it's like, 'I can listen. This is what it's about.'"

Points of improvement were also identified based on explicit relevancy, or lack thereof. The biggest critique of unclear relatability stemmed from the first campaign item, intended to target the general population, which each of the participants thought aimed to engage only those with depression. Said Johnny, "I think it states a bunch of facts, but does not give a reason why you should chat. It's implied." Ivy also thought a lack of direct engagement was an issue, saying,

I thought it was geared at [those with depression]. If I read it and I didn't have depression, I wouldn't think it was for me... So maybe have... more about how we should come together. Like, an encouraging point to make people understand, 'This is for me too. I can do something to make a difference.'

Johnny and Gary even began to brainstorm statements which could be added to the message to increase the explicitness of relevancy, such as "You can support your friends by talking, or chatting" and "So now let's chat, everyone."

Recommendations for the other campaign items were also provided on the basis of focus group members' explicit relevancy preference. Ivy and Gary thought that the

point about avoiding the perpetuation of misinformation about depression in the second campaign item should exclude the word myth, as to them it is more related to fantasy than reality. Participants also thought that the hashtag of the third item – “#ChatProfessionally” – was confusing. Ivy stated that “Chat professionally makes it sound like it’s really strict and not just about opening up more.” Johnny also thought that it sounded less like a recommendation to talk to mental healthcare providers and more “like the way I’m talking should be professional... You could change it to ‘chat with,’ or ‘chat to,’ or something.” Overall, the main points of praise and critique of the campaign items were centered on a dominant theme of preference for explicit expressions of relevancy.

Privacy concerns. A privacy concern theme began to emerge when the focus group considered the best media outlets for engaging in a campaign targeted at college students. Haley suggested that online articles would be the ideal method of message dissemination because of the supposed anonymity provided by the Internet. “No one is going to know if you’re clicking on it because it’s depression,” Haley said, “so you can do it in the privacy of your own home.” The freedom to hide engagement interest in depression was true for physical messages as well, highlighted by the suggestion that posters be made available in bathrooms. Ivy reflected,

You’re by yourself... You don’t feel embarrassed to stop and say, ‘I’m reading a poster about depression.’ You don’t want any judgment and in a place with a lot of people you would get that. So I’d be more inclined to stop when I’m comfortable and there’s no one around, than when I knew people were watching.

Stigma influences made focus group members obviously concerned about the privacy aspects of exposure to depression messages.

Privacy was particularly apparent when considering the third campaign item, which was intended to specifically target individuals with depression. “People might be embarrassed... If you’re going up to this, those around you, your peers are going to think or know that you’re depressed,” said Gary, “So this one might be best to be seen privately rather than in public.” Gary suggested that the third campaign item may be the best suited to online outlets, an idea Johnny supported and built upon, musing that “If it was more like a social media thing, with ‘let’s chat,’ you could – I don’t know how this would work – but you could have doctors or counselors online, available for anonymous chats.”

Gary responded with a comment that implies privacy concerns not just for the campaign item, but privacy concerns with the idea of professional mental health treatment in general. He stated that anonymity of online chats would be good, because

People may be embarrassed going into the counseling center. I know a friend of mine saw another friend of mine as she was going into the counseling center. And as she was going in, the friend was going out and avoided all eye-contact. And when she asked her about it later, she just kind of avoided it as a topic. Because she was embarrassed that she needed help. Some people have a lot of pride and they don’t want to be seen as vulnerable, like, how you could feel if you were going to the counseling center.

Clearly, focus group members had privacy concerns about the campaign, fearing that being seen reading the materials may lead to social judgment. This was especially true for the third campaign item targeting those with depression. Fears that engaging with that

item in particular would lead to an unwanted revelation or perception of depression led focus group members to recommend that the item be relegated to the supposed anonymity of social media networks and other Internet outlets.

Tension of tone. Though not a dominant theme, a brief moment of concentrated deliberation in the focus group is worthy of mention. It became apparent that a tension existed between the somewhat casual nature of the “chat” phrasing and the seriousness of depression. Gary first brought up this point, saying,

My opinion is these shouldn't be lighthearted campaigns. 'Chat positive,' that seems like, 'This is okay; you should do whatever you want,' when it's actually a pretty serious issue. And this may... make people feel like this issue isn't a big deal. It may be like, 'It's a lighthearted campaign; this issue is just happening.

The researcher affirmed that “this is a very utilitarian thing to say – but you want it palatable enough that people are willing to talk about it, but at the same time realize that it's real and its serious,” before asking the other participants if they thought the campaign did or did not strike an equal balance. Johnny said, “I see depression as a serious issue. But, this ad, campaign, would be a little more lighthearted, so it balances it out, for me at least.” Ivy didn't give an opinion, but did affirm that she clearly saw the tension existing in the campaign. Haley hinted at the campaign phenomenon of boomerang effects, stating,

I think it should be more on the positive, lighthearted side, because in the past I feel like you see a lot of depression campaigns or ads where it's so extreme. And if there's a message you keep getting exposed to that's so extreme, you'd be like... this is a little too much, I don't want to deal with this.

This was not a recurrent theme in the focus group discussion, but it was a moment which highlighted an essential aspect of consideration for the campaign moving forward.

Final Campaign Materials

A number of focus group recommendations were used for improvements (see Appendix C for revised campaign materials). The color scheme of each item has been changed to no longer consist of the official school colors and the messages have been made more specific. For the first item, the hashtag has been changed from “#ChatAcceptance” to “#Open2Chat” and the main message has been reorganized and reworded to emphasize relevancy for their friends and to include a call to action, “Let them know you’re #Open2Chat!” The second item’s hashtag was changed from “#ChatPositive” to “#Courage2Chat” and the main message adapted to clarify the steps, particularly the pursuit of knowledge. The third item had its hashtag changed from “#ChatProfessionally” to “#ChatWithPros” and its main message revised to more clearly target those with depression and communicate its purpose. Still to be included are relevant images.

CHAPTER 5: DISCUSSION

The current thesis attempted to address a pervasive issue on university campuses: depression among college students. An estimated 30% of college students will experience depression at some point during their college years (ACHA, 2012), but of those students diagnosed with depression, only 24% seek treatment (Hunt & Eisenberg, 2010). Health advocates often attempt to utilize the social power in interpersonal relationships of those in a targeted population with a particular health issue (Silk, Atkin, & Salmon, 2011). Research has suggested that depression can have significant, inverse relationships with social competencies and with stigma (Jones, Hobbs, & Hockenbury, 1982; Kreps, 1988; Wei, Russell, & Zakalik, 2005; Wright et al., 2013). Therefore, the present study on depression attempted to examine the social competency of willingness to communicate about depression (WTCD) and stigmas about depression.

Implications

Factors were measured through an online survey, which measured WTCD with friends and family, willingness to communicate with mental healthcare providers (WTCMHP), and personal and perceived stigma. Scales were adapted from prior existing instruments and were all shown to be reliable. Research question 1 investigated students' willingness to talk about depression by studying WTCMHP and WTCD with family and friends. Frequency reports indicated that students possess moderate levels of WTCMHP and WTCD. Focus group discussion revealed that students prefer communication about depression to happen with a select, intimate few, determined by perceptions of closeness, similarity, and communicative reciprocity. Survey data found that students are most

willing to talk about depression with their friends, followed by family, with mental healthcare providers eliciting the lowest willingness scores. It may be that friendships are thought to be more likely to provide self-verification (Wright, King, & Rosenberg, 2014), and thus are preferred communications about self-concept-sensitive topics such as depression. Focus group members did indicate that they thought friends would be more understanding, while family members would “overreact,” as Frankie stated, and mental healthcare providers would not offer substantive help, according to Carly.

Demographic comparisons showed no differences for WTC by sex, race, or year, failing to support previous research demonstrating that females have greater WTC than males (Wright, Frey, & Sopory, 2007). Demographic analysis also showed that gay/lesbian/other students were significantly more willing than straight/heterosexual students to talk with their friends about depression. That there is continued contention over sexuality in society would suggest that the experience of stigma in one area (homosexuality) may lead to increased sensitivity to stigma in another (depression). Finally, diagnoses of mental illness in both the past and present are associated with increased WTCMHP and WTCD, although being unsure if you are failing to seek treatment for a current mental illness is associated with significantly lower WTC scores. It is possible both that a lower willingness to communicate leads to individuals avoiding communicative opportunities in which they could discover their current mental health status, and/or that a lack of certainty creates anxiety which decreases communication willingness.

Research question 2 investigated the extent to which students possessed personal and perceived stigmas about depression. Frequency reports and an ANOVA indicated

that students have greater perceptions of stigma in others than they report having personally. Females and those with past mental illness diagnosis reported lower levels of personal depression stigma, suggesting the influence of sex and gender roles on the development of personal stigma. Differences may be biologically innate within sex or may be societally constructed through the hegemonic reinforcement of how males and females think about differences between in-groups and out-groups or about the gender-role appropriateness of engaging with emotions and feelings, such as depression.

Additionally, personal experience with mental illness is theorized to create a sense of empathy, thus leading to lower levels of personal depression stigma; having gone through a mental illness, the experience is more highly normed and thus not an uncommon topic of conversation. Moreover, perceived stigma decreased as year in school increased, with fourth years reporting significantly less perceived stigma than first years. Findings would suggest that some part of young adult development, possibly related to collegiate experiences, contributes to less negative attitudes of individuals about the attitudes of others.

Research questions 3 and 4 attempted to investigate what correlated and predictive relationships exist between depression stigma and WTC factors, finding that almost all variable scales correlated with each other, excluding perceived stigma which was only correlated with personal stigma. Regressions indicated that relationships between and among depression stigma and WTC measures are reciprocal cycles. For example, WTCMHP is predicted by WTCD with family, WTCD with friends, and personal depression stigma, while each of those variables are predicted by WTCMHP. WTCD with family and WTCD with friends also predict each other. Personal depression

stigma and perceived depression stigma likewise have a reciprocal predictive relationship. These findings are useful in that they demonstrate that WTC and stigma are intricately intertwined, though the complexity complicates theoretical understandings of causes and effects for both and how those influences might be manipulated.

That WTC can predict stigma and that stigma can predict WTC suggests a deeper connection: that communication competencies can influence attitudes and that attitudes can influence communication competencies. A reciprocal relationship of influence between attitudes and communication supports previous research (Fishbein & Ajzen, 1975; Ajzen 1991), and contributes to it with the specific incorporation of WTCD and depression stigma. Additionally, while regressions demonstrated that the variance predicted by the examined variables were moderate for WTCD with family (27%) and WTCD with friends (51%), the other variances were not as high; moderate and low variance prediction suggests other variables may exist which would serve as more impactful predictors of WTC and stigma measures. It may be the case that an outside variable determines both sets of factors simultaneously, which could begin to explain the reciprocal predictive relationships they share.

Recommendations

Because students reports higher willingness to communicate about depression with friends, campaign advocates would be advised to target friendships when attempting to use social support networks to destigmatize depression. However, as students were least willing to talk to mental healthcare professionals, such conversations may be stigmatized events in and of themselves which should be focused on to make more appealing. Campaigns encouraging interpersonal communication about depression should

attempt to educate potential communication partners about how to communicate self-verification in interactions, in order to boost perceptions of social support for those who have depression. Because gay/lesbian/other students were most willing to communicate with friends about depression, potentially because of a shared experience with marginalizing stigma, campaigns might want to explore connecting depression to comparable events in order to make it more understandable to audiences. Such an approach would need to be undertaken with caution, however, because the potential for boomerang effects as people associate depression with a possibly negative experience could actually increase stigma.

Because those who reported being unsure if they were failing to seek treatment for a current mental illness also reported significantly low WTC, campaigners might offer opportunities for individuals to clarify their own condition; which is admittedly a tough task to accomplish, since an unwillingness to engage in communication about mental health will make these populations difficult to successfully reach. Thus, research into sources of confusion would be helpful in adapting relevant campaign materials in response to conditions of uncertainty. If a new WTC about health scale is developed and utilized, campaigners could make use of comparative results in order to adapt campaign items to target the health issues individuals are most unwilling to communicate about and to target potential communication partners with whom those in need of care are most willing to communicate with about various health issues.

The findings that males have higher levels of personal depression stigma suggest that campaigns should find ways to especially target males by connecting aspects of their masculinity with decreased personal stigma. Potential avenues of outreach may include

messages which emphasize understanding and empathy through comparison to relatable sports or other extracurricular activities in which falling or injury is common and able to be recovered from, or notions of brotherhood or protection in order to speak to both masculinity and help-provision desires as conduits for norming interactions with those who made need help with depression. Again, it should be emphasized that messages should be wary of boomerang effects, and be cautious that messages attempting to increase WTC or decrease stigma through appeals to help-provision desires to not perpetuate in-group and out-group boundaries by categorizing individuals as those in need of help (who cannot help themselves) and those who have the power to provide that help. Research into what it is about the college experience that contributes to fourth-years having significantly lower perceived stigma than first years would also aid campaigns in revising relevant materials in order to attempt to magnify determinants and their effects. As focus group participants indicated, a perceived connection between those with depression and some form of fundamental flaw, a campaign, especially one following research identifying and investigating the nature and characteristics of perceived flaws, should attempt to educate publics about the inaccuracy of these assumptions. Literature suggests that breaking down such stereotypes can be best achieved by contact opportunities, in which members of a majority population to actually get to know those who have been stigmatized (Smith, 2011). This is opportune, considering the present thesis's finding that those who have experience with mental illness are especially willing to communicate about depression.

Analysis of focus group responses to campaign materials yields a number of additionally useful recommendations for advocates interested in campaign

implementation. For the dissemination of campaign materials, campaigners would do well to make items visually appealing, in terms of eye-catching imagery, and identify unique placement, such as stairwells or bathrooms. Dissemination should also take privacy concerns into account, allowing individuals to access materials both in public and in private. Content of destigmatizing messages should be sure to explicitly express intent and process. In other words, campaign items should specifically let the general public know that the message is for them, what the message is intended to achieve, and how individuals could properly respond to the message. Campaigns encouraging communication can also look to address the desire of individuals for their talk to be “helpful,” and should be aware of the tension between levity for gaining and maintaining attention and the seriousness of the depression.

Limitations

The current thesis did have a number of conditions which limited the study. Participants were overwhelmingly Caucasian, straight, female, first-year students, which limits generalizability to wider publics. Also, the present study did not measure behavioral intentions to actually communicate about depression specifically, which could have been studied as an outcome variable effected by various levels of WTC and stigma.

Time constraints prevented a fully qualitative investigation, as only two focus groups were conducted as supplemental sources of data. One focus group was intended to serve in a complimentary role to the quantitative survey, which allowed for statistical data to be understood on a more human level. However, the conduction of only one such focus group did not allow for thematic saturation. The experiences and stories which could have been communicated by other groups were unheard, thus leaving the data

without the potential nuance or conceptual completeness it might have achieved. The same critique could be made of the single focus group used to evaluate campaign materials. The experience of four individuals may not be generalizable to the responses campaign items may have generated from a larger population and theme development may be incomplete. The inclusion of several more focus groups, and the various perspectives they could have given voice to, would have also allowed the campaign materials to go through several conceptual and visual iterations – rather than a single set of revisions – and possibly be closer to readiness for actual implementation.

Additionally, the present thesis did not attempt to empirically measure campaign item effectiveness with pre- and post-tests for willingness and stigma measures, nor did the researcher roll out the campaign and conduct evaluative research. Finally, the proposed campaign included the incorporation of a social media approach, but it was an element which remained undeveloped materially and conversationally.

Future Directions

Future studies could attempt to gain samples which are more representative of university and general populations, including a greater number of males, persons of color and varied sexuality, and older students and adults. This would allow additional studies to continue to explore differences between sexes for WTC and to explore the link association between being gay/lesbian/other and higher levels of WTCD, examining exactly what it is about the subaltern experience of homosexual life which leads to greater WTCD. Further research could also include instruments of depression communication intention or actual engagement, to serve as outcome variables for WTC and stigma measures. Other academic work might delve into the subject on a greater

qualitative level, developing the initial themes which began to emerge in the two focus groups already conducted and searching for additional concepts inherent in the lived experience of individuals considering and engaging in communication about depression. Because social partner responses can determine perceptions of social support (Scott et al., 2013), which can influence health and levels of depression (Aseltine, Gore, & Colten, 1994; Dakof & Taylor, 1990; Dunkel-Schetter & Wortman, 1982), researchers should look to examine what role anticipated responses have in the development of WTCD among individuals.

Future research should look into the sources of uncertainty about current mental health status and examine the complexity of uncertainty's influence on WTC and health outcomes. This could start by redesigning the current study's measure of mental health experience. As is, the measure includes separate items for presently having a mental illness and seeking treatment and presently having a mental illness and not seeking treatment. The separation of items could cause confusion, so an adapted measure may simply include the past mental illness prompt and a single prompt for respondents to choose the statement which best reflected their current status, with answer options including "I do not know if I have a mental illness," "I do not currently have a mental illness," "I have a mental illness and am seeking treatment," and "I have a mental illness and am not seeking treatment." Such a revision would likely allow for improved comparison between groups based on current mental illness experience.

Based on differences between WTC with mental healthcare providers, family, and friends, future research about WTC should explore with whom individuals are most willing to communicate about health issues and the reasons behind such differentiation.

This could ultimately provide empirical support for the development of a new health-related WTC scale which involves all communication partners relevant to health, as existing health WTC scales often limit considerations of who is talked to (Wright, Frey, & Sopory, 2007) and what health issues are talked about (Morgan & Miller, 2002). In fact, no known studies have compared WTC about specific health issues among various communication partners. A new, more general WTC about health scale could then be adapted to any number of conditions, providing comparative power across health issues and among potential communication partner-specific subscales. Ultimately, this would let researchers quantitatively examine what health issues individuals are most and least willing to communicate about, and which partners in communication are most preferred for specific health topics. Studies could also qualitatively investigate why differences in WTC exist between health issues and why differences among communication-partners exist for those specific health issues. Further qualitative research would be especially helpful when recalling how focus groups revealed how family members can also be considered friends. How relationships which simultaneously belong to various classifications come to exist and what effect they may have on perceptions of social support when considering health issues would be an important area of study.

Further studies into stigma can investigate larger constructs of sex, gender, and experience and look to explore exactly what it is about development in college that decreases perceived stigma, along with studying in more detail the influences of sex and past mental illness diagnosis. Because focus groups reflected previous research (Goffman, 1963) and indicated that stigma is intimately connected to stereotypes which assume a fundamental flaw within stigmatized persons, research could attempt to

understand what fundamental flaw may be perceived within depressed persons. The intricate ties between WTC and stigma should lead researchers to compare intensity and duration of influence and if any moment in the reciprocal stigma-WTC reproduction process can be empirically found be more idyllic for destigmatizing and/or communication-willingness-increasing intervention efforts. In light of low-to-moderate variance prediction, further studies could attempt to discover a more holistic view of determinant factors; what they are and how they interact to lead to particular levels of WTC and stigma.

Future research and campaign design would do well to incorporate pilot-testing as part of formative analysis, measuring for effects of campaign exposure. Further implementation would also call for process and evaluative analysis as well. Finally, as an underdeveloped opportunity in the present study, future campaign research should seek to discover the most efficient and effective method of utilization of social media resources within the overall campaign.

Conclusion

The present thesis attempted to investigate antecedent attitudes and behaviors which might contribute to low depression treatment rates among university students by examining stigma and willingness to communicate. Survey and focus group data revealed that students have moderate levels of WTC and stigma, with greater willingness to talk to friends about depression than others, and a greater sense that others have more stigmatized attitudes than they have themselves. These variables were shown to influence each other in significant, and often reciprocal, ways. Focus groups supplemented survey data and themes which emerged through discussion included WTC, perceived stigma,

help-provision desires, and perceptions of low public knowledge of severity. Campaign materials were created in response to this initial data and the second focus group articulated need for explicit expressions of relevance and concerns about privacy when viewing messages. Campaign materials were subsequently adapted. Continuing this work will contribute to WTC and depression campaign research literature and to actually moving towards the implementation of real, depression-destigmatizing and/or WTC-encouraging campaigns for university students. So let's keep chatting.

Appendix A

IRB Approval Notification

Morgan, Cindy - morgancs <morgancs@jmu.edu>

Tue 12/2/2014 2:07 PM

Inbox

To: Smith, Ethan Daniel - smith5ed;

Cc: Carmack, Heather Janelle - carmachj <carmachj@jmu.edu>;

Dear Ethan,

I wanted to let you know that your IRB Protocol entitled, "***Communicating about Mental Health and Depression***," has been approved effective from 12/2/2014 through 12/1/2015. The signed action of the board form, approval memo, and close-out form will be sent to you via campus mail. Your protocol has been assigned No. 15-0269. Thank you again for working with us to get your protocol approved.

All research must be conducted in accordance with this approved submission, meaning that you will follow the research plan you have outlined in your protocol, use approved materials, and follow university policies.

Please take special note of the following important aspects of your approval:

- Any changes made to your study require approval ***before*** they can be implemented as part of your study. Contact the Office of Research Integrity at researchintegrity@jmu.edu with your questions and/or proposed modifications. An addendum request form can be located at the following URL: <http://www.jmu.edu/researchintegrity/irb/forms/irbaddendum.doc>.
- As a condition of the IRB approval, your protocol is subject to annual review. Therefore, you are required to complete a Close-Out form before your project end date. You *must* complete the close-out form unless you intend to continue the project for another year. An electronic copy of the close-out form can be found at the following URL: <http://www.jmu.edu/researchintegrity/irb/forms/irbcloseout.doc>.
- If you wish to continue your study past the approved project end date, you must submit an Extension Request Form indicating a renewal, along with supporting information. An electronic copy of the close-out form can be found at the following URL: <http://www.jmu.edu/researchintegrity/irb/forms/irbextensionrequest.doc>.
- If there are in an adverse event and/or any unanticipated problems during your study, you must notify the Office of Research Integrity within 24 hours of the event or problem. You must also complete adverse event form, which can be located at the following URL: <http://www.jmu.edu/researchintegrity/irb/forms/irbadverseevent.doc>.

Although the IRB office sends reminders, it is ultimately *your responsibility* to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

Thank you again for working with us to get your protocol approved. If you have any questions, please do not hesitate to contact me.

Best Wishes,

Cindy Morgan

Administrative Assistant, Office of Research Integrity

James Madison University

Blue Ridge Hall, Room # 342, MSC 5738

Harrisonburg, VA 22807

Phone: (540) 568-7025

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Email: morgancs@jmu.edu

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Appendix B

Survey Questions:

Willingness to Communicate with Mental Health Care Providers

1-Strongly disagree, 2-disagree, 3-neutral, 4-agree, 5-strongly agree

1. I am comfortable communicating with mental health care providers.
2. I am willing to communicate with mental health care providers.
3. I know how to communicate with mental health care providers.
4. I experience difficulties communicating successfully with mental health care providers. (R)
5. I am quick to make an appointment to talk with a mental health care provider when I'm not feeling well.
6. When I don't feel well, I don't want to talk to a mental health care provider. (R)
7. I frequently talk to mental health care providers.
8. I actively seek out mental health care providers.
9. I would only talk to mental health care providers if I absolutely had to. (R)
10. I consider it informative to talk with mental health care providers.
11. I consider it enjoyable to talk with mental health care providers.

Willingness to Communicate about Depression

Below are a series of statements concerning your own communication about depression. Please read each statement carefully and select the response which best describes how much you agree or disagree with each statement.

1-Strongly disagree, 2-disagree, 3-neutral, 4-agree, 5-strongly agree

1. I would be comfortable talking with my family about depression.
2. I would be comfortable talking with my friends about depression.
3. I know how to talk with my family about depression.
4. I know how to talk with my friends about depression.
5. I am willing to talk with my family about depression.
6. I am willing to talk with my friends about depression.
7. I have talked with my family in the past about depression.
8. I have talked with my friends in the past about depression.
9. I anticipate talking with my family in the future about depression.
10. I anticipate talking with my friends in the future about depression.
11. I consider it informative to talk with my family about depression.
12. I consider it informative to talk with my friends about depression.
13. I consider it enjoyable to talk with my family about depression.
14. I consider it enjoyable to talk with my friends about depression.

Attitudes Toward Depression

Personal Depression Stigma

Below are a series of statements concerning your own beliefs about depression. Please read each statement carefully and select the response which best describes how much you agree or disagree with each statement.

1-Strongly disagree, 2-disagree, 3-neutral, 4-agree, 5-strongly agree

1. People with depression could snap out of it if they wanted.
2. Depression is a sign of personal weakness.
3. Depression is not a real medical illness.
4. People with depression are dangerous.
5. It is best to avoid people with depression so you don't become depressed yourself.
6. People with depression are unpredictable.
7. If I had depression I would not tell anyone.
8. I would not employ someone if I knew they had been depressed.
9. I would not vote for a politician if I knew they had been depressed.

Perceived Depression Stigma

Below are a series of statements concerning the beliefs of others about depression. Please read each statement carefully and select the response which best describes how much you agree or disagree with each statement.

1-Strongly disagree, 2-disagree, 3-neutral, 4-agree, 5-strongly agree

1. Most people believe that people with depression could snap out of it if they wanted.
2. Most people believe that depression is a sign of personal weakness.
3. Most people believe that depression is not a medical illness.
4. Most people believe that people with depression are dangerous.
5. Most people believe that it is best to avoid people with depression so that you don't become depressed yourself.
6. Most people believe that people with depression are unpredictable.
7. If they had depression, most people would not tell anyone.
8. Most people would not employ someone they knew had been depressed.
9. Most people would not vote for a politician they knew had been depressed.

Below are a series of demographic questions. These items can be equally important as others in a survey. Please answer each question.

What is your sex?

Male

Female

What is your age?

What is your race/ethnic background?

White/Caucasian

Black/African-American

Hispanic/Latino

Asian

Pacific Islander

Native American

Other

What year are you in school?

First

Second

Third

Fourth

Fifth

Graduate Student

What is your sexual orientation?

Straight/Heterosexual

Gay/Lesbian/Bisexual

Other

Please select the response which best describes you:

1 = No

2 = Unsure

3 = Yes

I have been diagnosed by a health provider with a mental illness in the past.

I currently have a mental illness and am seeking treatment.

I currently have a mental illness and am not seeking treatment.

Focus Group 1 Discussion Protocol:

How often do you talk about mental health?

Probe: Topics? Why or why not?

Who do you talk to about mental health?

What do you say about mental health?

Do you think you know how to talk about depression?

Probe: What do you need for a “good” conversation?

Probe: What makes up a “good” conversation about depression?

How comfortable are you talking about depression?

Probe: What would make you more or less comfortable?

How willing are you to talk about depression?

Probe: With various others (friends, family, providers)?

Probe: What would make you more or less willing?

Who do you talk about depression with?

What do you say about depression?

Do you think other college students know how to talk about depression?

Probe: What do they need for a “good” conversation?

How comfortable are other college students talking about depression?

Probe: What would make them more or less comfortable?

How willing are other college students to talk about depression?

Probe: With various others (friends, family, providers)?

Probe: What would make them more or less willing?

Who do other college students talk about depression with?

What do other college students say about depression?

Focus Group 2 Discussion Protocol:

Do you think you know how to talk about depression?

How comfortable are you talking about depression?

Probe: What would make you more or less comfortable?

How willing are you to talk about depression?

Probe: With who? (friends, family, providers)

Do you think other college students know how to talk about depression?

How comfortable are other college students talking about depression?

Probe: What would make them more or less comfortable?

How willing are other college students to talk about depression?

Probe: With who? (friends, family, providers)

What type of media is most effective at reaching college students?

Probe: Examples?

Present Campaign Item 1

What do you think about this campaign material?

Would it catch your attention or the attention of others?

What do you think about the depression information provided?

Would it encourage you or others to talk more about depression?

Do you have any recommendations for improvement?

Campaign Item 2

What do you think about this campaign material?

Would it make you or others feel more prepared to talk about depression?

Would it encourage you or others to communicate positively about depression?

Do you have any recommendations for improvement?

Campaign Item 3

What do you think about this campaign material?

Would you or others be more open to recommending a mental health care professional?

Would you or others be more willing to talk to a mental health care professional?

Do you have any recommendations for improvement?

What is your overall impression of the campaign?

Do you have any overall recommendations for improvement?

Appendix C

Initial Materials

#ChatAcceptance

Depression: (1) Emotions that interfere with everyday life in a big way, (2) A common problem

Why Chat?

- 30% of college students – aka your friends! - will experience depression
- Only 24% of students diagnosed will seek treatment
- Suicide is the 3rd cause of death among young people age 15-24

@LetsChatJMU

#ChatPositive

Depression: (1) Emotions that interfere with everyday life in a big way, (2) A common problem

How to Chat:

- Get some knowledge
 - We don't want to pass along rumors or myths!
- Get some courage
 - You don't have to be comfortable, just willing!
- LISTEN!!!

@LetsChatJMU

#ChatProfessionally

Depression: *(1) Emotions that interfere with everyday life in a big way, (2) A common problem*

Why Chat?

- We have regular doctor and dentist appointments...
- Seeing a counselor for a mental check-up is just as normal.
- Counseling Center
 - Student Success Center 3rd Floor
 - 540-568-6552

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Revised Materials

#Open2Chat

Depression: *(1) Emotions that interfere with everyday life in a big way, (2) A common problem*

Why Chat?

- 30% of college students
aka YOUR FRIENDS!
will experience depression
- Are you willing to listen and talk?
- Let them know you're #Open2Chat!

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#Courage2Chat

Depression: (1) Emotions that interfere with everyday life in a big way, (2) A common problem

How to Chat:

- Have the #Courage2Chat
 - You don't have to be comfortable, just willing!
- Have the Compassion to Listen
- Have the Knowledge to Help
 - Do some research to find out what depression is really about

@LetsChatJMU

#ChatWithPros

Depression: (1) Emotions that interfere with everyday life in a big way, (2) A common problem

Why Chat?

- 30% of college students have depression; you're not alone!
- Talking with friends is great; but sometimes we all need a little more help
- A mental health check-up is normal & professionals can help!

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